Dr. Wells

99

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

12724

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Hours

Hospital, institution, or street address where death occurred:
Cearfoss Garage

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 912 Hamilton Blvd
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME

Paul ~~Joseph~~ Baker, Paul Joseph

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Male~~ Mk	White	Married

6.(b) Name of husband or wife: Elsie M.

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): May 9 1900

8. AGE: Years	Months	Days	If less than one day
45	6	25	...hrs. ...min.

9. Birthplace: Mason-Dixon Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: Garage Owner

11. Industry or business: Cearfoss Garage

FATHER 12. Name: Daniel Baker

FATHER 13. Birthplace: Masin Dixon pa.

MOTHER 14. Maiden name: Lillian Bowers

MOTHER 15. Birthplace: Hagerstown Md.

16. Informant: Mrs. Elsie Baker

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/7/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec - 6 1945 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1945 19..., at about 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: carbonmonoxide poisoning	acute
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of Dec/4/45

Where did injury occur? Hagerstown (City or town) Wash Md. (County) (Cearfoss (State)

Injured at home, farm, industry, public place (where?) Bakers' Garage

Means of injury: fell asleep in closed garage with motor running

23. SIGNATURE: Robert Wells DEPUTY MEDICAL EXAM. WASH. CO. MD. M. D. or Coroner

Address: Hagerstown Md. Date signed: Dec 5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Hornbaker 1282 732

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Franklin
City or town: Greencastle
(If outside city or town limits, write RURAL and give nearest town)
Street No.: So. Carlisle St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Brown Barnhart

3.(b) Social Security Number: 179-12-4544

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): July 24 1900

8. AGE: Years	Months	Days	If less than one day
45	5	7	..... hrs. ..... min.

9. Birthplace: Shady Grove Franklin Co. Pa.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Landis Tool Co.
FATHER 12. Name: Charles Barnhart
13. Birthplace: Shady Grove Pa.
MOTHER 14. Maiden name: Catherine R. Linganfelter
15. Birthplace: Shady Grove Pa.
16. Informant: Amanda Barnhart
Address: Greencastle Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/46 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Greencastle Pa.
18. Funeral director: A E. Minnich
Address: Greencastle Pa.
19. Jan. 1 1946 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: December 31 1945 at 8.40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-29 1945 to 12/31 1945 and that I last saw him alive on 12/31 1945

Immediate cause of death	DURATION
Diabetic Coma	60 hours (?)
Due to: Diabetes mellitus	10 years (approx)
Due to:	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. Le H Hornbaker M. D.
Address: 147 W. Washington St. Hagerstown, Md. Date signed: 1/1/46
(M. D. or other)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

145

12726

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Mo.
Hospital, Institution, or street address where death occurred:
Security, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Security
(If outside city or town limits, write RURAL and give nearest town)
Street No.: None
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Edsel Barnhart

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1945

8. AGE: Years	Months	Days	If less than one day
	1	21	hrs. min.

9. Birthplace: Hagerstown, Washington, Md. (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business

FATHER
12. Name: Cohen Edsel Barnheart
13. Birthplace: Indinia

MOTHER
14. Maiden name: Catherian Seekord
15. Birthplace: Hagerstown, Md.

16. Informant: E. I. Hurd
Address: Security, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Maryland

18. Funeral director: E. W. Kraiss
Address: Hagerstown, Maryland.

19. Dec 28 1945 (Date rec'd by registrar) Chas. H. Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25, 1945 19 5:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24 19 45 to Dec. 25 19 45
and that I last saw him alive on Dec. 23 19 45

Immediate cause of death	DURATION
Due to Bronchial pneumonia	2 dy
Due to Premature infant	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B. Grather M. D. or other
Address: Hagerstown, Md Date signed: 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. P. Wells 42

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

12727

CERTIFICATE OF DEATH

★ Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 132 Blooms Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Harry Odell Barton Jr.

3. (b) Social Security Number: 213-12-7017

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): May 1 1919

8. AGE: Years	Months	Days	If less than one day
26	7	2	..... hrs. ..... min.

9. Birthplace: Hagerstown wash. Co. Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Junk Yard
FATHER 12. Name: Harry O. Barton Sr.
FATHER 13. Birthplace: Greencastle Pa.
MOTHER 14. Maiden name: Ella Smith
MOTHER 15. Birthplace: waynesboro Pa.
16. Informant: Mrs. Ella S. Barton
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/5/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstwon Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Dec 5 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1945 19 at 4:58 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Fracttred skull hemorrhage	
Due to and shock	11hr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 12/1/45
Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Wash. County Jail
Means of injury: Fell and struck head Injured at work? No

DEPUTY MEDICAL EXAM.
WASH. CO., MD.

23. SIGNATURE: L. Robert Wells M. D. or other
Address: Hagerstown Md. Date signed: 12/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Mar 26 1866

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington County

City or town Hagerstown Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:
Washington County Home Hagerstown Md.

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Sharpsburg Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George W. Beeler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 26 1866

8. AGE: Years	Months	Days	If less than one day
79	8	21	....hrs. ....min.

9. Birthplace Sharpsburg, Maryland (Town, county, and state)

10. Usual occupation General Carpenter

11. Industry or business Carpenter

FATHER 12. Name George Beeler

13. Birthplace Unknown

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Mr. Allen Poffenbarger

Address Sharpsburg Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 19 1945 (month) (day) (year)

Cemetery or crematory Tolson Cemetery

Location Sharpsburg, Maryland

18. Funeral director Edith V Leaf

Address #7 Church St. Williamsport, Md.

19. Dec. 19 1945 (Date rec'd by registrar) Grant Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17th. 1945, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 1945 to Dec. 17 1945 and that I last saw him alive on Dec 12th. 1945

Immediate cause of death	DURATION
Hypertension	5yrs.
Arteriosclerosis	"
Due to Hemiplegia	1day.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest J Coblentz M. D.

Address Hagerstown Md. Date signed 12/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Victor Miller
12729

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:
Washington county Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Summit Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Cora Amelia Boward

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William L.

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): September 27 1860

8. AGE: Years	Months	Days	If less than one day
85	2	25	... hrs. ... min.

9. Birthplace: Hagerstown -ash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: John Munson
13. Birthplace: Hagerstown Md.

MOTHER
14. Maiden name: No Record
15. Birthplace: No Record

16. Informant: Mrs. Bertha Hose
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/45 (month) (day) (year)

Cemetery or crematory: Ross Hill Cemetery

Location: Hagerstwon Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec 24, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: December 22 1945 19... at 1.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15 1945 to 12/22 1945

and that I last saw h... alive on 12/21 1945

Immediate cause of death	DURATION
Chronic End Carditis	
" "	
Arterio-	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: V. Victor Dwellen M. D. or other

Address: ... Date signed 12/22 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12739

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 18 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rear 55 W. Franklin
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dorsey Boward

3.(b) Social Security Number: 212-24-5844

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Not Known

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace: Hagerstown, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles E. Boward
13. Birthplace: Hagerstown, Maryland

MOTHER
14. Maiden name: Sarah J. Koons
15. Birthplace: Hagerstown, Maryland

16. Informant: Ross Boward
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-26-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Dec 26, 1945 (Date rec'd by registrar) Elast H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec/23 19 45 at 5/23 /p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Second degree burns to	
Due to face, upper extremities	18hrs
Due to abdomen and thigs	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Dec/22/45
Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: burned stove caught fire Injured at work?

23. SIGNATURE: S. Robert Wells M. D.
Address: Hagerstown Md Date signed: 12/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12731 No 13

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: High St.

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.: High St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Jennie S. Bowers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name at husband or wife: Franklin Bowers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 19 - 1870

8. AGE: Years 74 | Months 11 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: near Myersville Fred. Co. Md. (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Own Home.

FATHER — 12. Name: Henrick Susman

FATHER — 13. Birthplace: Fred. Co. Md.

MOTHER — 14. Maiden name: Polly Moore

MOTHER — 15. Birthplace: Fred. Co. Md.

16. Informant: Mrs. John T. Marty

Address: Boonsboro Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Dec. 20 1945 (month) (day) (year)

Cemetery or crematory: Mt. Lena Cemetary

Location: Mt. Lena Md.

16. Funeral director: Wm. J. Bast & Sons

Address: Boonsboro Md.

19. Dec. 20 1945 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 1945 at 8 a P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1945 to Dec. 18 1945 and that I last saw her alive on December 18 1945

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to: Uraemia	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. W. Kelly M. D. M. D., or other

Address: Boonsboro Md. Date signed 12/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1860)

CERTIFICATE OF DEATH

12732

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington County
City or town: Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 631 W Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Nannie Bowers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Deceased
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 14 1862

8. AGE: Years	Months	Days	If less than one day
83	4	26	____ hrs. ____ min.

9. Birthplace: Sharpsburg Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Jacob Schoppert
13. Birthplace: Sharpsburg Md.
MOTHER 14. Maiden name: Elizabeth Lopp
15. Birthplace: Sharpsburg Md.
16. Informant: Mrs. Elizabeth Drenner
Address: 631 W. Franklin St. Hagerstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11 1945 (month) (day) (year)
Cemetery or crematory: Rosehill Cemetery H
Location: Hagerstown Maryland
18. Funeral director: Edith V Leaf
Address: # 7 Church St. Williamsport, Md.
19. Dec. 11 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 1945 2 1/4 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 45 to Dec 9 1945 and that I last saw her alive on Dec. 9 1945

	DURATION
Immediate cause of death: ____	
Due to: cerebral thrombosis	
Due to: fracture of femur (neck)	
Due to: fall	
Other conditions: extreme age	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: Absent J. Call Walker
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter Lapenas M.D.
M. D. or other
Address: Hagerstown, Md. Date signed: 12-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

12733

(159)

1. PLACE OF DEATH

County Washington — Registration Dist. No. 300

Village or City Hagerstown — No. Washington County Hospital St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs ___ mos. 1½ ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Thomas Richard Bowers — If U. S. Veteran, specify WAR None

(a) Residence: No. Bargar, Wash. Co., Md. St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) December 22, 1945

7. AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
—	—	1½	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. None

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Hagerstown (State or country) Maryland

FATHER

13. NAME Samuel F. Bowers

14. BIRTHPLACE (city or town) Samples Manor (State or country) Maryland

MOTHER

15. MAIDEN NAME Viola Leonora Shouse

16. BIRTHPLACE (city or town) Williamsport (State or country) Maryland

17. INFORMANT Mrs. Viola L. Bowers (Address) R.F.D. #1, Harpers Ferry, West Va.

18. BURIAL, CREMATION, OR REMOVAL Place Samples Manor, Md. Date Dec. 25, 1945

19. UNDERTAKER E. L. Eackles (Address) Bolivar West Va.

20. FILED 12-26, 1945 Edgar Boyer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Dec. 24 (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Birth, 19__, to Dec. 23, 19 45; I last saw h__ alive on Dec. 23, 19 45; death is said to have occurred on the date stated above, at 8:35 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Atelectasis of Lungs.	Birth
Prematurity — 8 months.	

Other Contributory Causes of importance:

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19__

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? ___

If so, specify ___

(Signed) Walter H. Shreeve M. D.

(Address) Sharpsburg, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Dr. Ditto

12734

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred:
Roessner Ave Extd.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. Roessner Ave Extd
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Emma Seibert Bowman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: J.W.E.

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): July 27 1880

8. AGE: Years	Months	Days	If less than one day
65	4	5	....hrs. ....min.

9. Birthplace: Cearfoss Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Lewis E. Seibert
13. Birthplace: Cearfoss Md.

MOTHER
14. Maiden name: Lillie Cearfoss
15. Birthplace: Cearfoss Md.

16. Informant: J.W.E. Bowman
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec. 4. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1945 19..., at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26. 45 19... to Dec 2- 19 45 and that I last saw h... alive on Dec - 2 - 45 19...

Immediate cause of death	DURATION
Influenza	4 wks
Due to	
Due to	
Other conditions Pulmonary T.B	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: J. W. E. Bowman M. D. or other

Address: Hagerstown Md. Date signed 12/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12735

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 1/2 days

Hospital, Institution, or street address where death occurred: Washington County Hospital, Hagerstown

How long in hospital or institution? 4 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Chewsville, Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: Main St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel C. Bowman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna M. Bowman

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1897

8. AGE:	Years	Months	Days	If less than one day
	48	2	26	..... hrs. ..... min.

9. Birthplace: Frederick County, Md. (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Western Md. R. R. Co.

FATHER — 12. Name: John Bowman

FATHER — 13. Birthplace: Fredk. Co., Md.

MOTHER — 14. Maiden name: Carrie Pryor

MOTHER — 15. Birthplace: Fredk. Co., Md.

16. Informant: Mrs. Edna M. Bowman

Address: Chewsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18, 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Wolfesvill, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown

19. Dec 18, 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1945 at 9 30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1945 to Dec 15 1945 and that I last saw h... alive on Dec 15 1945

Immediate cause of death	DURATION
Duodenal Ulcer (ruptured)	7 days
Due to	
Due to	
Other conditions: Embolism (L. lung)	6 hours

(Include pregnancy within 3 months of death)

Major findings of operations: Rupture of duodenal ulcer Ventomutes Date of op. 12-11-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert P. Conrad M.D. M. D. or other

Address: Hagerstown, Md Date signed 12-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

18

12736

Reg. Dist. No. 306

1. PLACE OF DEATH:
County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lewis Albert Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma C. Smith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1856

8. AGE: Years	Months	Days	If less than one day
89	1	22	....hrs. ....min.

9. Birthplace Foxville Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Ignatius Brown
13. Birthplace Frederick, Md.

MOTHER
14. Maiden name Susan Buhrman
15. Birthplace Md.

16. Informant Louis H. Brown
Address Mt. Zion. Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof 12/24/45 (month) (day) (year)
Cemetery or crematory Bethel Cemetery
Location Washington Co. Md.

18. Funeral director Walter H. Grove
Address 721 Church St. Waynesboro, Pa.

19. Dec 27 1945 (Date rec'd by registrar) Geo. W. Tregoning Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1945 about 6A 19...., at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Chronic cardio-vascular	
Due to disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. A. Beem M. D.
Address Hagerstown, Md. Date signed 12/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12737

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:
County: Washington
City or town: Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lindsay Alley
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Rebbeca Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 19 1928

8. AGE: Years	Months	Days	If less than one day
17	3	24	hrs. min.

9. Birthplace: Williamsport Md (Town, county, and state)
10. Usual occupation: house work
11. Industry or business: Home
12. FATHER — Name: Noah Brown
13. FATHER — Birthplace: Williamsport Md
14. MOTHER — Maiden name: Annie Elizebeth Broadus
15. MOTHER — Birthplace: Lurray Va.
16. Informant: Noah Brown
Address: Williamsport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 151945 (month) (day) (year)
Cemetery or crematory: Riverview Cem
Location: Williamsport Md
18. Funeral director: Edith V. Leaf
Address: Williamsport Md
19. Dec. 14. 45 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/12/45 19.... at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/11/45 19.... to 12/12/45 19.... and that I last saw h.. alive on 12/12/45 19....

Immediate cause of death: Influenza

DURATION: 4 Days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. F. Young M. D. or other
Address: Williamsport, Md. Date signed: 12/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

12738

Reg. Diat. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Clearspring, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Clearspring, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert Ward Carbaugh

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Effie Carbaugh
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): December 18 1870

8. AGE: Years	Months	Days	If less than one day
75	0	3	....hrs. ....min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business

FATHER
12. Name: John Carbaugh
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Margret Greer
15. Birthplace: Pennsylvania

16. Informant: Mrs. Effie Carbaugh
Address: Clearspring, Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24 1945 (month) (day) (year)
Cemetery or crematory: St. Pauls Cemetery
Location: Clearspring, Md.

18. Funeral director: Snyder-Rowland
Address: Clearspring, Md.

19. Dec 23 1945 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 December 1945 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 July 1938 to 21 Dec. 1945 and that I last saw him alive on 13 December 1945

Immediate cause of death	DURATION
Coronary occlusion. acute	1 min.
Due to: Dr. Fibro Sclerotic cardio-vascular renal disease	8 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None.
Date of op.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Curtis Robert Coles M. D. or other
Address: Clearspring, Md. Date signed: 22 Dec. 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

127347

Reg. Diat. No. 306

1. PLACE OF DEATH

County: Wash.

City or town: Smithsburg and

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yr.

Hospital, institution, or street address where death occurred: -

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Smithsburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. - - - -

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Martha Ellen Coe.

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: William Coe

6.(c) If alive, give age: 70 years

7. Birth date of deceased (Mo., day, yr.): Dec. 23 1875

8. AGE:

Years	Months	Days	If less than one day
68	6	1	- hrs. - min.

9. Birthplace: Boonsboro. Md (Town, county, and state)

10. Usual occupation: Housekeeping

11. Industry or business: - - -

FATHER

12. Name: Daniel Smith

13. Birthplace: Hagerstown Md

MOTHER

14. Maiden name: Malinda Smith Not Known

15. Birthplace: Hagerstown Md

16. Informant: William Coe

Address: Smithsburg Md

17. Burial (Burial, cremation, or removal?) Date thereof 12-27-1945 (month) (day) (year)

Cemetery or crematory: Smithsburg Md

Location: Smithsburg Md

18. Funeral director: Lee B. Rooms

Address: Smithsburg Md

19. Dec 24 1945 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 1945 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 24 1945 and that I last saw her alive on Dec 24 1945

Immediate cause of death	DURATION
Pulmonary Edema	6 hrs
Due to Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	10 yrs
Other conditions -	

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: G. G. Holder M. D. or other

Address: Smithsburg Md Date signed 12/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (546)

CERTIFICATE OF DEATH

12740

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:

106 North Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 North Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward G. Catron

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bartha A. Catron

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	28	..... hrs. ..... min.

9. Birthplace: Rural Retreat- Wyth Co., Va. (Town, county, and state)

10. Usual occupation: Fairchild Aircraft

11. Industry or business: Assembly Dept.

FATHER

12. Name: Franklin Catron

13. Birthplace: Wyth County, Va.

MOTHER

14. Maiden name: Nancy Ellen ------

15. Birthplace: Wyth County, Va.

16. Informant: Mrs. Bartha A. Catron

Address: 106 North Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 26, 1945 (month) (day) (year)

Cemetery or crematory: Harbaugh Cemetery

Location: Near Ringgold, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Dec 26. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 22, 1945 at 11:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Malignant tumor of brain	9 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: as above May 1945

University Hosp. ; Balto Md Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J Robert Wells M.D.

M. D. .....

Address: Hagerstown, Md. Date signed 12/24/45

(M) (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Hornbaker 138

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

12741

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Hours

Hospital, institution, or street address where death occurred:
1117 Oak Hill Ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 57 Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs. Virginia Gilbert Chaffinch

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Lawrence H.

6.(c) If alive, give age: —— years

7. Birth date of deceased (mo., day, yr.): April 29 1881

8. AGE: Years	Months	Days	If less than one day
64	8	0	...hrs. ...min.

9. Birthplace: Stevensville Kent Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Rev David Gilbert
13. Birthplace: Havre de Grace Md.

MOTHER
14. Maiden name: Ida Hayman
15. Birthplace: Stevensville Md,

16. Informant: Mrs. John H. Hornbaker
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/46 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md

19. Jan 1 1946 (Date rec'd by registrar) Elsie H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-29 1945, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 19..., to 12-29 1945 and that I last saw her alive on 12/29 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage -	18 Hours -
Due to: Hypertensive vascular disease	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: John H Hornbaker Jr. M.D.

Address: 154 W. Washington St. Hagerstown, Md. M. D. or other

Date signed: 12/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wells

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 12743 302

1. PLACE OF DEATH:
County: Washington
City or town: Funkstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Hours
Hospital, Institution, or street address where death occurred: Kellers Cabins
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No.: Berner Ave (If rural, give LOCATION)
2.(a) If veteran, name war: World War # 2

3. (a) FULL NAME: Harry J. Chaney Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth A.
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): December 2 1920

8. AGE: Years	Months	Days	If less than one day
25	0	7	....hrs. ....min.

9. Birthplace: Adametown Fred. Co. Md. (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: Newton D. Baker Hosp.
FATHER 12. Name: Harry J. Chaney
13. Birthplace: Monrovia Md.
MOTHER 14. Maiden name: Rachael E. Frazer
15. Birthplace: Frederick Md.
16. Informant: Ruth V. Armstrong
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/17/45 (month) (day) (year)
Cemetery or crematory: Bellview Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Dec. 17 1945 (Date rec'd by registrar) Chas H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1945 19..., at about 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Asphyxia by carbon	.....
Due to monoxide gas.	minute
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Dec. 9-45
Where did injury occur? Funkstown (City or town) Washington (County) Md. (State)
Injured at home, farm, industry, public place (where?) Kellers Cabins
Means of injury: asphyxia by carbon monoxide gas Injured at work? No
DEPUTY MEDICAL EXAM. WASH. CO., MD.
23. SIGNATURE: H Roher S Wells M. D. or other
Address: Hagerstown Md. Date signed 12/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

12743

CERTIFICATE OF DEATH

Reg. Diat. No. 301

1. PLACE OF DEATH:

County Washington County

City or town Smithburg Maryland RFD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, Institution, or street address where death occurred:
Smithburg Md. RFD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Smithburg Md RFD
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Buleah Catherine Cline

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Fred Cline

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22 1895

8. AGE: Years	Months	Days	If less than one day
50	11	3	hrs. min.

9. Birthplace Smithburg Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name Charles E Bowers
13. Birthplace Downsville Md.

MOTHER
14. Maiden name Mary Catherine Bowers
15. Birthplace Downsville Md.

16. Informant Fred Cline
Address Smithburg Md. RFD #

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30 1945 (month) (day) (year)

Cemetery or crematory Greenlawn Cemetery
Locaflon Williamsport, Md.

18. Funeral director Edith V Leaf
Address # 7 Church St. Williamsport, Md.

19. Dec. 28 1945 (Date rec'd by registrar) Mrs E Le McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Multiple sclerosis	5 yrs.
Due to coronary occlusion	3 wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE L Rahn Wells M. D. or [illegible]
DEPUTY MEDICAL EXAM.
WASH. CO., MD.

Address Hagerstown, Md. Date signed 12/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

12744 2

CERTIFICATE OF DEATH

Reg. Diat. No. 304

1. PLACE OF DEATH:

County: Washington

City or town: Hancock, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hancock, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Ellen Corbett

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Eugene Corbett

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): October 26 1877

8. AGE: Years	Months	Days	If less than one day
68	2	4	hrs. min.

9. Birthplace: Washington Co.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER — 12. Name: Samuel Degnan

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Mary Slagle

MOTHER — 15. Birthplace: Washington Co.

16. Informant: Eugene Corbett

Address: Hancock, Md. Rural

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Jan. 4 1946

Cemetery or crematory: Methodist Cemetery

Location: Hancock, Md.

18. Funeral director: Snyder - Rowland

Address: Hancock, Md.

19. (Date rec'd by registrar) January 1 19 46 J. H. Keller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 19 45 at 6:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-30 19 45 to 12-30 19 45 and that I last saw h.. alive on 12-30 19 45

Immediate cause of death	DURATION
Carcinoma of cervix	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herbert R. Zobus M.D.
M. D. or other

Address: Hancock, Md. Date signed 1-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Brown

12745

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Weeks

Hospital, institution, or street address where dsath occurred: 17 High St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 High St.

(If rural, give LOCATION)

2.(a) If vetsran, name war: None

3.(a) FULL NAME: Daniel Henry Cosey

3.(b) Social Security Number: None

4. Sex	5. Color or race	8.(a) Single, marrisd, widowed, or divorced
Male	White	Widower

6.(b) Nams of husband or wife: Mary C.

6.(c) If alive, givs age: -yssrs

7. Birth date of deceased (mo., day, yr.): February 17 1868

8. AGE: Years	Months	Days	If less than ons day
77	9	26	...hrs. ...min.

9. Birthpisce: Coseytown Franklin Co. Pa. (Town, county, and state)

10. Usual occupstion: Laborer

11. Industry or businsss: Retired

FATHER — 12. Name: Daniel Cosey

13. Birthplacs: Coseytown Pa.

MOTHER — 14. Msiden name: No Record

15. Birthpisce: Non Record

16. Informant: Fonrose Cosey

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/15/45 (month) (day) (year)

Csmetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral dirsctor: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec 14 1945 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: December 13 1945 at 12.10 M

21. I CERTIFY that dsath occurred on the dats abovs stated; that I attended deceassd from Dec 2 1945 to Dec 12 1945 and that I lsst saw h... alivs on Dec 12 1945

Immediate cause of death	DURATION
Auricular fibrillation	4 wks
Due to	
Due to	
Other conditions: Constipation with indigestion	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Dats of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death wss due to external causes, fill in the following:

Accident, suicids, or homicide: ... Dats of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Mssns of injury ... Injured at work?

23. SIGNATURE: W M Allan Jr MD M. D. or other

Address: 164 W Wash St Dats signed: Dec 13 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12746 148

Dr. Conrad

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, institution, or street address where death occurred:
2003 Lexington Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2003 Lexington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Barbara E. Cummings

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widow

6.(b) Name of husband or wife: Peter S
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 19 1859

8. AGE: Years	Months	Days	If less than one day
86	1	19	hrs. min.

9. Birthplace: Chamburg Franklin Co. Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Steven Shatzer
13. Birthplace: Chambersburg, Pa.
MOTHER 14. Maiden name: Eliz. Myers
15. Birthplace: Chambersburg Pa.
16. Informant: Mrs. A. R. Coldsmith
Address: Hagertown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/30/45 (month) (day) (year)
Cemetery or crematory: Salem Cemetery
Location: Near Chambersburg Pa.
18. Funeral director: A.E. Minnick
Address: Greencastle Pa.
19. Dec. 28 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

40 A

20. DATE OF DEATH: Dec 28 1945 at 8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1945 to Dec 28 1945 and that I last saw h-ew alive on Dec 28 1945

Immediate cause of death	DURATION
Chr. Myocarditis	5 yrs
Due to	
Due to	
Other conditions: Grippe	8 days.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert P. Conrad, M.D.
M. D. or other
Address: Hagerstown, Md Date signed 12-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

12747

CERTIFICATE OF DEATH

Reg. Dist. No. 30 2

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

434 George Street

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 434 George St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George W. Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Davis

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 14, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	25	____ hrs. ____ min.

9. Birthplace: Fountaindale-Fredk., Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Janitor

FATHER — 12. Name: Charles W. Davis

FATHER — 13. Birthplace: Fredk. Co., Md.

MOTHER — 14. Maiden name: Anna ----------

MOTHER — 15. Birthplace: Fredk. Co., Md.

16. Informant: Mrs. George W. Jones

Address: 434 George St.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Dec. 8 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6, 1945 19____ at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1-45 19____ to Dec 6-45 19____ and that I last saw h.... alive on Dec 3 45 19____

Immediate cause of death	DURATION
Chr Myocarditis	2 y.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 12/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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12748

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, Institution, or street address where death occurred: 427 N. Mulberry St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wash.

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 427 N. Mulberry St.

(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: George F. Dennis, Sr.

3.(b) Social Security Number: 214-16-0736

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bessie V. Dennis

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): July 17, 1879

8. AGE:	Years	Months	Days	If less than one day
	66	5	9	...hrs. ...min.

9. Birthplace: Faquir County, Virginia (Town, county, and state)

10. Usual occupation: –

11. Industry or business: –

FATHER — 12. Name: Lloyd P. Dennis

FATHER — 13. Birthplace: Faquir County, Va.

MOTHER — 14. Maiden name: Nancy J. Brown

MOTHER — 15. Birthplace: Faquir County, Va.

16. Informant: Mr. John Dennis

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 28, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Scott F. Minnich & Son

Address: Hagerstown, Md.

19. Dec 28 1945 (Date rec'd by registrar) Chas. H. Boevers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26, 1945, at 11:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-2-43 19..., to 12-26 19 45 and that I last saw h... alive on 12/26/45 19...

Immediate cause of death	DURATION
arteriosclerotic Heart Disease & Auricular fibrillation	Unknown - probably about 10 years.
Due to	
Due to	
Other conditions –	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: John H. Hornbaker M. D. M. D. or other

Address: 15d W. Washington St. Hagerstown, Md. Date signed: 12/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 838

CERTIFICATE OF DEATH

12749

Reg. Dist. No. 304

1. PLACE OF DEATH:
County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME
Elmer Ellsworth Dickerhoff

3. (b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Bessie Heller Dickerhoff 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 14, 1867

8. AGE: Years	Months	Days	If less than one day
78	7	28	... hrs. ... min.

9. Birthplace Millstone, Washington Co., Md (Town, county, and state)

10. Usual occupation Painter

11. Industry or business —

FATHER 12. Name Sam Dickerhoff
13. Birthplace Millstone, Md.

MOTHER 14. Maiden name Mary Jane Myers
15. Birthplace Millstone, Md.

16. Informant Clarence V. Dickerhoff
Address Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 16, 1945 (month) (day) (year)
Cemetery or crematory Riverview Cemetery
Location Hancock, Md.

18. Funeral director Charles R. Bast
Address Hancock, Md

19. Dec 15 1945 (Date rec'd by registrar) J. M. Keller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942, to 12-12 1945
and that I last saw h... alive on 12-12 1945

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to Senile Debility	
Due to	
Other conditions Hypotension with cerebral thrombosis	6 mo

(Include pregnancy within 8 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Herbert R. Zohn M.D. M. D. or other
Address Hancock, Md. Date signed 12-14-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-0)

CERTIFICATE OF DEATH

12736-2

Reg. Dist. No. 301

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Washington County

City or town: Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs

Hospital, institution, or street address where death occurred:
S. Artizan St. Williamsport, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: S. Artizan St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Emma Dickerhoff

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel Dickerhoff deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 8 1860

8. AGE: Years	Months	Days	If less than one day
85	4	14	..... hrs. ..... min.

9. Birthplace: Williamsport Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Edward Reichter
13. Birthplace: Germany

MOTHER
14. Maiden name: Caroline Potts
15. Birthplace: Williamsport, Md

16. Informant: Calvin Dickerhoff (son
Address: Lebonan Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24 1945 (month) (day) (year)

Cemetery or crematory: Riverview Cemetery

Location: Williamsport, Maryland

18. Funeral director: Edith V Leaf

Address: #7 Church St. Williamsport, Md.

19: Dec 24 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/21/45 19..., at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/8/45 19... to 12/21/45 19...

and that I last saw her alive on 12/21/45 19...

Immediate cause of death: Hypostatic Pneumonia — DURATION: 2 Days

Due to: Fractured Neck of Femur — 2 Wks.

Due to: Accidental fall. Cause

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of December 7th, 1945

Where did injury occur? Williamsport (City or town) Washington (County) Maryland (State)

Injured at home, farm, industry, public place (where?): At home

Means of injury: Accidental fall Injured at work?

23. SIGNATURE: L. F. Young M. D. or other

Address: Williamsport, Md. Date signed: 12/23/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

12751

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 Yrs.
Hospital, Institution, or street address where death occurred:
639 Penn. Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 639 Penn. Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Fannie Dorsey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1876

8. AGE: Years	Months	Days	If less than one day
69	9	6	hrs. min.

9. Birthplace Chambersburg Pa.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden name
15. Birthplace
16. Informant Mrs. Pearl Williams
Address 639 Penn. Ave.,
17. Burial Date thereof 1/2/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Greencastle, Pa.
18. Funeral director Wm. H. Downey
Address 291 Frederick St.
19. Jan 2 1946 Chas. H. Avey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1945 at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Chr. Myocarditis	3 yrs
Due to: acute pulmonar edema	
Due to: fibrillation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no
Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert Wells Exam. Med. Ex.
M. D. or other
Address Hagerstown Md Date signed 1/1/46

14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

12752 303

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Big Pool (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Big Pool (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William F. Dougherty

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clementine Dougherty

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): December 25, 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	11	27		

9. Birthplace: Washington County (Town, county, and state)

10. Usual occupation: Retired Railroad Repairman

11. Industry or business: Railroad

FATHER 12. Name: William Dougherty

FATHER 13. Birthplace: Washington County

MOTHER 14. Maiden name: Not Known

MOTHER 15. Birthplace: Not Known

16. Informant: Mrs. Clementine Dougherty

Address: Big Pool, Md.

17. St. Paul's Cemetary (Burial, cremation, or removal. Which?) Dec. 26, 1945 (month) (day) (year)

Cemetery or crematory: Near Clear Spring

Location:

18. Funeral director: Snyder - Rowland

Address: Clear Spring, Md.

19. Dec 26 19 45 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23, 1945, at 7.30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19, 1945, to Dec 23, 1945 and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Chr. Brights Dis.	2 yrs.
Due to: Arterio Sclerosis	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David R. Brewer M. D. or coroner

Address: Clear Spring Md. Date signed 12/23/45

12753 109

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 329 North Cannon Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 329 North Cannon Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: William E. Downs

3.(b) Social Security Number: 214-09-6784

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Oressie V. Downs
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): March 8, 1894

8. AGE:	Years	Months	Days	If less than one day
	51	9	2	...hrs. ... min.

9. Birthplace: Williamsport, Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Silk Weaver
11. Industry or business: Maryland Ribbon Company
FATHER 12. Name: Freeland Downs
13. Birthplace: Williamsport, Maryland
MOTHER 14. Maiden name: Mary E. Sprecker
15. Birthplace: Williamsport, Maryland
16. Informant: Mrs. William E. Downs
Address: Hagerstown, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-12-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland
18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland
19. Dec 11 1945 Chas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10, 1945, at 7:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 24, 1945 to Dec. 10, 1945 and that I last saw him alive on Oct. 24, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	15 Min.
Due to: Angina Pectoris & Arteriosclerosis	1 Yr. 4 Mo. +
Due to: Chronic rheumatoid lung and pleurisy chron.	1918
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: X Date of: X
Where did injury occur? (City or town) X (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Howard Yeager M. D. or other
Address: Hagerstown Date signed: Dec. 10, 45

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

12754 103

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington Co.

City or town Rural (Paramount)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Hagerstown R.D. 4

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Rural Paramount Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Hagerstown R.D. 4
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME CORA MAE EBY

3. (b) Social Security Number 219-20-1572

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21st 1913

8. AGE:

Years	Months	Days	If less than one day
32	6	16	hrs. min.

9. Birthplace Washington Co. Md
(town, county, and state)

10. Usual occupation Clerk

11. Industry or business Potato Chip Factory

FATHER 12. Name David R. Eby

13. Birthplace Washington Co. Md.

MOTHER 14. Maiden name Archie Martin

15. Birthplace Washington Co. Md.

16. Informant David M Eby

Address Hagerstown #4

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10/45 (month) (day) (year)

Cemetery or crematory Ruffs Mennonite Church

Location Washington Co. Md.

18. Funeral director Mrs David Martin

Address Greencastle, Pa.

19. Dec 8 1945 Chas H. Bowers, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1945, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---19---, to ---19---, and that I last saw h---alive on ---19---.

Immediate cause of death	DURATION
Bronchial asthma	5yrs
Due to Toxic thyroid 1940 (operated)	
Due to Chr. myocarditis	5yrs
acute ventricular fibrillation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy NO

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Robert Wells DEPUTY MEDICAL EXAM WASH. CO., MD.
M. D. (Coroner)

Address Hagerstown Md Date signed Dec 8/45

93

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

12755

★ Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 years
Hospital, institution, or street address where death occurred:
Wash. County Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20½ Bellevue Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Adrian L. Ernde

3.(b) Social Security Number: 220-09-7543

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 10, 1906

8. AGE: Years	Months	Days	If less than one day
39	3	21	hrs. min.

9. Birthplace: Hagerstown- Wash. Md.
(Town, county, and state)

10. Usual occupation: Silk Worker

11. Industry or business:

FATHER
12. Name: Charles W. Ernde
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Alice Barnes
15. Birthplace: ---------- Pa.

16. Informant: Mrs. Alice Ernde
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Dec 4 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1, 1945 10:35 A. at M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Intracerebral hemorrhage	39h rs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Nov/29/45
Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Blooms' alley
Means of injury: fell down steps Injured at work? No

23. SIGNATURE: C Robert Mills DEPUTY MEDICAL EXAM. WASH. CO. M. D. or other
Address: Hagerstown, Md. Date signed: 12/3/45

Dr Noble Smith

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13512

Reg. Diat. No. 305

1. PLACE OF DEATH:
County: Washington
City or town: Mt. Lena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Main St.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Mt. Lena
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Ada Irene Faulders.

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lewis W. Faulders.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 20 - 1889

8. AGE: Years	Months	Days	If less than one day
56	3	22	..... hrs. ..... min.

9. Birthplace: Mt. Lena Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Elmer Bowman
13. Birthplace: Mt. Lena Wash. Co. Md.
MOTHER 14. Maiden name: Annie Houpt.
15. Birthplace: near Myersville Fred. Co. Md.
16. Informant: Lewis W. Faulders
Address: Boonsboro Md. R. 2.
17. Burial. (Burial, cremation, or removal. Which?) Date thereof: December 15 1945 (month) (day) (year)
Cemetery or crematory: Mt. Lena Cemetary
Location: Mt. Lena Wash. Co. Md.
18. Funeral director: Wm. D. Bast & Sons
Address: Boonsboro Md.
19. Dec 14 1945 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 1945 at 6.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945, to Dec 12 1945
and that I last saw her alive on Dec 12 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Nephritis & Uremia	6 yrs
Due to Cardiac Hypertrophy & Hypertension	16 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: G. G. Koller M. D. or other
Address: Sharpsburg Date signed: 12/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12730 7

Dr. Moore.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Washington
City or town: Sandy Hook - Rural.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks.
Hospital, institution, or street address where death occurred:
R. D. Knoxville Md.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Washington
City or town: Mt. Brion. Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Knoxville Md. R. 1.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Effie Lovenia Ferguson

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Freeling Ferguson.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Febry. 29. 1876

8. AGE:

Years	Months	Days	If less than one day
69	9	6	..... hrs. ..... min.

9. Birthplace: Burkittsville Fred. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own Home
FATHER 12. Name: John Smith
13. Birthplace: Fred. Co. Md.
MOTHER 14. Maiden name: Elizabeth Gaylor.
15. Birthplace: Fred. Co. Md
16. Informant: Harold Ferguson.
Address: Knoxville Md.
17. Burial. Date thereof: Dec. 9. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Boonsboro Cemetary
Location: Boonsboro Md.
18. Funeral director: Wm. D. Bast & Sons.
Address: Boonsboro Md.
19. Dec. 7 1945 Cornelius H. Castle Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945 at 9:30 P. M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ November 30, 1945, to Dec. 5, 1945
and that I last saw her alive on Dec. 5, 1945

Immediate cause of death	DURATION
Rheumatic Heart Disease,	.....
Aortic Stenosis	2
Due to	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of .....
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury — Injured at work? —

23. SIGNATURE: S. G. Moore M. D. or other
Address: Harpers Ferry, W Va. Date signed: 12-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

Reg. Diat. No. 12358

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 219 East Baltimore Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Isabelle T. Fletcher

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George W. Fletcher

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 27, 1876

8. AGE: Years	Months	Days	If less than one day
69	11	18	..... hrs. ..... min.

9. Birthplace: Winchester, Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: John Wesley Winkfield

FATHER — 13. Birthplace: Funkstown, Maryland

MOTHER — 14. Maiden name: Amanda Moore Wiley

MOTHER — 15. Birthplace: Winchester, Virginia

16. Informant: Douglas Fletcher

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-17-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. DEC 17 1945 (Date rec'd by registrar) Earl H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15, 1945, at 2.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23, 1945, to Dec. 15, 1945 and that I last saw h... alive on Dec. 14, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	4 Hours
Arteriosclerosis	10 yrs. ?
Due to: Bronchial Pneumonia	8 days
Due to: Stroke (Cva)	6 "
Due to: Bilateral Hernia Ventral	15 yrs.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. Howard Geiger M. D. or other

Address: Hagerstown Md Date signed: Dec. 15, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12751 107

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, Institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Franklin
City or town: Chambersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 So. Federal
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Helen Elizabeth Flory

3.(b) Social Security Number: 175-03-4759

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John N. Flory
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 8. 1908

8. AGE: Years	Months	Days	If less than one day
37	1	0	..... hrs. ..... min.

9. Birthplace: Williamsen Va. (Town, county, and state)
10. Usual occupation: Telephone Operator
11. Industry or business
FATHER 12. Name: Robert A. Bender
13. Birthplace: McConnellsburg, Pa
MOTHER 14. Maiden name: Lillian Bowers
15. Birthplace: McConnellsburg Pa
18. Informant: John N. Flory
Address: Chambersburg Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 12. 1945 (month) (day) (year)
Cemetery or crematory: Corpus Christi Cem.
Location: Chambersburg Pa.
18. Funeral director: Robert Sellers
Address: Chambersburg, Pa.
19. Dec. 10, 1945 (Date rec'd by registrar) Ethel Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 December 19 45 at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 DEC 19 45, to 8 DEC 19 45 and that I last saw h. alive on 8 DEC 19 45

Immediate cause of death	DURATION
Congestive heart failure with pulmonary edema, acute	2 weeks
Due to: Rheumatic Heart Disease	3 mo.
Due to:	
Other conditions: Possible choriocarcinoma malignancy, not proven (Include pregnancy within 3 months of death)	?

Major findings of operations: ..... Date of op. .....
Autopsy results: Autopsy refused

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: William D Layman, M.D. (M. D. or other)
Address: 107 Professional Arts Bldg Date signed: 10 Dec 45
Hagerstown, Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

91

12760

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 107 East Howard Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

H. Welty Garver

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie I. Garver

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): April 10, 1865

8. AGE: Years	Months	Days	If less than one day
80	7	22	...hrs. ...min.

9. Birthplace: Waynesboro, Pa.
(Town, county, and state)

10. Usual occupation: Retired Machinist

11. Industry or business

FATHER 12. Name: John W. Garver

13. Birthplace: Smithsburg, Maryland

MOTHER 14. Maiden name: Eliza A. Lehman

15. Birthplace: Hagerstown, Maryland

16. Informant: Mrs. H. Welty Garver

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-4-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Dec. 4 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 1945 at 4:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1945 to Dec 2 1945 and that I last saw h... alive on Dec 1 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	11/28/45
Due to Arteriosclerosis	?
Hypertension	?
Due to Myocarditis Chr	3
	1
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: H. H. Porterfield M.D.
M. D. or other

Address: 136 W Washington Date signed 12/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

12761 no 15

CERTIFICATE OF DEATH

★ Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Boonsboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Gapland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Richard Theodore Cates

3.(b) Social Security Number: 212-14-7173

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marguerite Gates

6.(c) If nlive, give nge years

7. Birth date of deceased (mo., day, yr.): June 17, 1906

8. AGE: Years	Months	Days	If less than one day
39	6	9	hrs. min.

9. Birthplnce: Gapland-Wash.-Md.
(Town, county, and state)

10. Usual occupation: Tile Setter

11. Indostry or business

FATHER — 12. Name: S. Asbury Cates

13. Birthplace: Hagerstown, Md.

MOTHER — 14. Maiden name: Cora May Smith

15. Birthplace: Loucust Grove, Md.

16. Informant: Mr. Lee Cates

Address: Keedysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-1945 (month) (day) (year)

Cemetery or crematory: Fair-View

Location: Keedysville, Md.

18. Funeral director: R. I. Earnshaw

Addrens: Keedysville, Md.

19. Dec. 27, 1945 (Date rec'd by registrar) John N. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26, 1945 at 2:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1945, to Dec. 25, 1945; and that I last saw h alive on Dec 21, 1945.

	DURATION
Immediate cause of death: Coronary Thrombosis	4 days.
Due to: Malignant Hypertension	?
Due to:	
Other conditions: Chronic Parenchymatous Nephritis.	?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causen, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meann of injury: Injured at work?

23. SIGNATURE: Walter H. Shealy M.D. M. D. or other

Address: Sharpsburg, Md. Date signed 12/26/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

12762

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, Institution, or street address where death occurred:
42 East Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 42 East Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henrietta K. Hagerman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles E. Hagerman

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): April 1, 1868

8. AGE: Years	Months	Days	If less than one day
77	8	7	....hrs. ....min.

9. Birthplace: Franklin County, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Jonas Kieffer
13. Birthplace: Franklin County, Pa.

MOTHER
14. Maiden name: Henrietta Eliman
15. Birthplace: Franklin County, Pa.

16. Informant: Charles E. Hagerman
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-10-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Dec. 10. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1945, to December 8, 1945 and that I last saw her alive on December 7, 1945

Immediate cause of death	DURATION
Myocardial failure	12 hours
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death).

Major findings of operations: No operations Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. A. Breu M. D. or other

Address: Hagerstown, Md. Date signed: 12/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12763

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Security
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
Security
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Security
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Edward Harman

3.(b) Social Security Number: 213-10-6787

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Harman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 11, 1882

8. AGE:	Years	Months	Days	If less than one day
	63	6	2	hrs. min.

9. Birthplace: Washington County, Md.
(Town, county, and state)
10. Usual occupation: Stone Mill
11. Industry or business: No. Amer. Cement Co.
FATHER 12. Name: George W. Harmon
13. Birthplace: Frederick Co. Md.
MOTHER 14. Maiden name: Martha M[illegible]
15. Birthplace: Md
16. Informant: Mrs. Helen Harman
Address: Security, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 17, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Md.
18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.
19. Dec 15 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13, 1945 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 1945, to Dec 13 1945 and that I last saw h[illegible] alive on Dec 13 1945

Immediate cause of death	DURATION
Coronary Heart Disease	
Due to: Hypertension and Arteriosclerosis	
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert V. L. Campbell MD M. D. or other
Address: 145 W. Washington St. Date signed: Dec 14, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12764

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wash.

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 148 N. Potomac St.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Howard F. Hartman

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Bell Hartman

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): October 24, 1873

8. AGE:	Years	Months	Days	If less than one day
	72	2	2	...hrs. ...min.

9. Birthplace: Strites Mill, Wash., Md. (Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business: Law

FATHER — 12. Name: Andrew Hartman

FATHER — 13. Birthplace: near McConnellsburg, Penna.

MOTHER — 14. Maiden name: Mary Speck

MOTHER — 15. Birthplace: near Leitersburg, Md.

16. Informant: Mr. Harry Hartman

Address: Boonsboro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Scott F. Minnich & Son

Address: Hagerstown, Md.

19. Dec. 28 19 45 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26, 1945 at 4:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-1-45 19... to 12-26-45 19... and that I last saw h... alive on 12/26/45 19...

Immediate cause of death	DURATION
Congestive Heart Failure	3 wks
Due to	
Due to	
Other conditions Cancer Lung	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hagerstown Md. Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

164

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12765

940

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Elm Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Albert Hastings

3.(b) Social Security Number: 215-18-2784

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Hastings

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): December 3, 1880

8. AGE: Years	Months	Days	If less than one day
65	0	8	...hrs. ...min.

9. Birthplace: Mooresville, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Bank Messenger

11. Industry or business: Nicodemus National Bank

FATHER
12. Name: Thomas Hastings
13. Birthplace: Mooresville, Maryland

MOTHER
14. Maiden name: Lucinda Martin
15. Birthplace: Mooresville, Maryland

16. Informant: Mrs. Albert Hastings
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-14-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Dec 13 19 45 (Date rec'd by registrar) Earl H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 19 45 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 19 45 to Dec 11 19 45 and that I last saw h[illegible] alive on December 11 19 45

Immediate cause of death	DURATION
(a) Coronary Thrombosis	4 hrs.
Due to	
Due to	
Other conditions: Carcinoma of Prostate.	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: D. N. Bradley M. D. or other

Address: Hagerstown, Md. Date signed: Dec 11 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

1276

Dr. Prather

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown R.F.D.#2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Years
Hospital, institution, or street address where death occurred:
Huyetts Cross Road
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Jonas Washington Hoffman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

8.(b) Name of husband or wife: Barbara
8.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.): Nov. 4 1868

8. AGE: Years	Months	Days	If less than one day
77	I	25	....hrs. ....min.

9. Birthplace: Mt. Lena Washington Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Active

FATHER
12. Name: George Hoffman
13. Birthplace: Myersville Md.

MOTHER
14. Maiden name: Amanda C. Houpt
15. Birthplace: Myersville Md.

16. Informant: Miss Mary Hoffman
Address: Hagerstown, R.F.D. # I

17. Burial (Burial, cremation, or removal. Which?) Date thereof: I/I/46 (month) (day) (year)
Cemetery or crematory: Fahrney's Cemetery
Location: Mapleville Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Jan. 1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 1945 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1940 to Dec. 29 1945 and that I last saw h— alive on Dec. 29 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 da.
Due to Hypertension	10 yrs
Due to Chronic nephritis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.: ....

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of: ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ....
Means of injury: ....Injured at work?

23. SIGNATURE: B. Prather M. D. or other
Address: Hagerstown Md. Date signed: 12.31.45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Porterfield

102

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

12767

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Hagerstown Hospital
How long in hospital or institution? 8 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1468 Oak Hill Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Margaret Lee Hoover

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	S.

6.(b) Name of husband or wife: —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb 14 - 1944

8. AGE: Years 1 | Months 9 | Days 22 | If less than one day: hrs. min.

9. Birthplace: Hagerstown Wash Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: E Glenn Hoover
13. Birthplace: Waynesboro Pa.

MOTHER
14. Maiden name: Ellen Leaker
15. Birthplace: Hagerstown Md.

16. Informant: E Glenn Hoover
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/45 (month) (day) (year)
Cemetery or Crematory: Green Hill
Location: Waynesboro Pa.

18. Funeral director: Walter Y Stone
Address: Waynesboro Pa

19. Dec. 8, 1945 (Date rec'd by registrar) Grace H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6 1945, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945, to Dec 6 1945
and that I last saw h...er alive on Nov 16 1945

Immediate cause of death	DURATION
Unknown to await autopsy results.	
Due to: Autopsy findings: Right heart dilatation	
Due to: Diagnosis: Paroxysmal tachycardia and	
Other conditions: acute dilatation. C.H.F.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: To be reported.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H S Porterfield M.D.
M. D. or other
Address: 136 W Washington Date signed: 12/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

David L. Horst

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

12763

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Maugansville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Maugansville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME David L. Horst

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Alice Horst
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1872

8. AGE: Years 72 | Months 11 | Days 11 | If less than one day: hrs. min.

9. Birthplace (town, county, and state): Washington County, Md.

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: Joseph Horst
13. Birthplace: ------- Pa.

MOTHER
14. Maiden name: Fannie Lesher
15. Birthplace: ------- Pa.

16. Informant: Elsie Horst
Address: Maugansville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1945 (month) (day) (year)
Cemetery or crematory: Reiffs Cemetery
Location: Cearfoss, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Dec 3 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 2. 1945 at 5:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 5, 1941 to Dec. 2, 1945 and that I last saw h[illegible] alive on Dec. 1, 1945

Immediate cause of death	DURATION
Cardiac Failure	Nov. 26, 1945
Due to (Chronic Myocarditis)	Aug. 1941
Angina Pectoris	
Due to arteriosclerosis	5 yrs.?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. —
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Howard Yeager. M. D. or other
Address Hagerstown Md. Date signed Dec. 2, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

12769

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington County
City or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Fenton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Hose

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femlae	White	Widowed

6.(b) Name of husband or wife David Hose deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 3 1860

8. AGE: Years	Months	Days	If less than one day
85	1	5	..... hrs. ..... min.

9. Birthplace Broadfording Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name James Guessford
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Ellen Potts
15. Birthplace Maryland
16. Informant Charles Hose (son)
Address Williamsport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12 1945 (month) (day) (year)
Cemetery or crematory St. Pauls Cemetery
Location Near Clearspring Md.
18. Funeral director Edith V Leaf
Address Williamsport, Md.
19. Dec 12 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1945 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/10/45 19.. to 12/10/45 19.. and that I last saw her alive on 12/10/45 19..

Immediate cause of death	DURATION
Coronary Occlusion	2 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C Eglevy M. D. or other
Address Williamsport Md Date signed 12/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

130

12771

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington County
City or town: Hagerstown Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 307 Conococheague St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rebbeca Ann Hose

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Baby

6.(b) Name of husband or wife: Baby
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 29 1945

8. AGE: Years	Months	Days	If less than one day
	1	20	hrs. min.

9. Birthplace: Williamsport, Md. (Town, county, and state)
10. Usual occupation: Baby
11. Industry or business

FATHER
12. Name: James W. Hose
13. Birthplace: Williamsport, Md

MOTHER
14. Maiden name: Alice Vaughn
15. Birthplace: Halfway Md.

16. Informant: Alice Hose (Mother)
Address: 307 Conococheague St. Williamsport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 22 45 (month) (day) (year)
Cemetery or crematory: Greenlawn Cemetery
Location: Williamsport, Md.

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. Dec 21 19 45 (Date rec'd by registrar) E. Earl Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/19/45 19 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/18/45 19 to 12/19/45 19 and that I last saw h[illegible] alive on 12/19/45 19

Immediate cause of death	DURATION
Influenza	3 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. F. Young M. D. or other
Address: Williamsport, Md. Date signed: 12/21/45

no 14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1277

Reg. Diat. No. 305

Dr. Wade

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Washington

City or town Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

S. Main St.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No. S. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Clarence Luther Houpt

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Pearl Houpt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 8 1882

8. AGE: Years	Months	Days	If less than one day
63	10	11	..... hrs. ..... min.

9. Birthplace Near Myersville Fred. Co. Md.

(Town, county, and state)

10. Usual occupation Retired House Painter

11. Industry or business

FATHER 12. Name Peter Houpt

13. Birthplace Fred. Co. Md.

MOTHER 14. Maiden name Etta Miller

15. Birthplace Wash. Co. Md.

16. Informant Earl Houpt

Address Dunkelsburg Md.

17. Burial Date thereof Dec. 22. 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. D. Bast & Sons

Address Boonsboro Md.

19. Dec 22 1945 John W. Bast

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19" 1945 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April - 1 - 1936 to Dec. 19" 1945

and that I last saw him alive on October 26 - 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Hubert Nader M.D. M. D. or coroner

Address Boonsboro Md. Date signed 12/21/45

Dr. Campbell

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12772

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 851 Guilford Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1

3. (a) FULL NAME: Jacob Franklin House

3. (b) Social Security Number: 705-10-7402

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel G.

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): July 10 1892

8. AGE: Years	Months	Days	If less than one day
53	5	14	....hrs. ....min.

9. Birthplace: Shenandoah Shenandoah Co. Va.
(Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: W. M. R. R.

FATHER — 12. Name: William House

13. Birthplace: Shenandoah Va.

MOTHER — 14. Maiden name: Leona Coverstone

15. Birthplace: Shenandoah Va.

16. Informant: Mrs. Ethel G. House

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/27/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec. 26. 1945 (Date rec'd by registrar) Chas. H. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 1945, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 21 1945 to Dec 24 1945 and that I last saw him alive on Dec 23 1945

Immediate cause of death	DURATION
Bronchopneumonia	6-7 days.
Due to Chronic Bronchitis	15 yrs.
Due to Bronchial Asthma	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: .... Injured at work?

23. SIGNATURE: W. R. Campbell M. D. or other

Address: Hagerstown Md. Date signed: Dec. 24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1784)

CERTIFICATE OF DEATH

Reg. Dist. No. 1277 302

1. PLACE OF DEATH:

County: Washington

City or town: Funkstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Hours

Hospital, institution, or street address where death occurred:

Kellers Cabins

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn tufonts give residence of mother)

State: Maryland County: Washigton

City or town: Hagerston

(If outside city or town limits, write RURAL and give nearest town)

Street No. 805 Woodland Way

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Page Rooklin Householder

3.(b) Social Security Number: 220-16-2066

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Betty

6.(c) If alive, give age: 18 years

7. Birth date of deceased (mo., day, yr.): January 4 1926

8. AGE: Years	Months	Days	If less than one day
19	11	5	...hrs. ...min.

9. Birthplace: Cearfoss Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Anderson Dry Cleaning Co.

FATHER — 12. Name: John H. Householder

FATHER — 13. Birthplace: Dry Run Md.

MOTHER — 14. Maiden name: Mary Weaver

MOTHER — 15. Birthplace: Clearspring Md.

16. Informant: Mrs. Genevieve Troupe

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/12/45 (month) (day) (year)

Cemetery or crematory: Dunkard Cemetery

Location: Broadfording Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Deacmber 9 1945 19... About 3A at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Asphyxia due to	acute
Due to: carbonmonoxide poisoning	
Due to:	
Other conditions	

(Include pregnency within 3 months of death)

Major fiodiogs of operatious: ...Date of op.

Aotopsy results: No

PHYSICIAN: Please underlioe the caose to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Dec/9/45

Where did injury occur? Funkstown (City or town) Wash (County) Md. (State)

Injured at home, farm, industry, public place (where?): Kellers' Cabins

Means of injury: gas stove in small room, asleep Injured at Work?

DEPUTY MEDICAL EXAM. WASH. CO., MD.

23. SIGNATURE: J. Rohrer Wells M. D. or other

Address: Hagerstown Md. Date signed: 12/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

134

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

12774

Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-1

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Weeks
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 6 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Funkstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie E. Johnson

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W. Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 17, 1878.

8. AGE: Years	Months	Days	If less than one day
67	1	5	..... hrs. ..... min.

9. Birthplace: Funkstown
(Town, county, and state)
10. Usual occupation: Home work
11. Industry or business

FATHER
12. Name: Jacob Bierly
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen Leckron
15. Birthplace: Maryland

16. Informant: John W. Johnson
Address: Funkstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24, 1945 (month) (day) (year)
Cemetery or crematory: Funkstown
Location: Funkstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown,

19. Dec 23 1945 (Date rec'd by registrar) C. Kastt Bowers Registrar

MEDICAL CERTIFICATION

11-15

20. DATE OF DEATH: December 22 1945 at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3, 1945, to Dec. 22, 1945
and that I last saw h... alive on December 22, 1945

Immediate cause of death	DURATION
Endarteritis	3½ mo.
Due to: Diabetes Mellitus	18 yrs.
Due to:	
Other conditions: Multiple abscesses	2 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: No operations — Date of op.
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: R. A. Bird M. D. or other
Address: Hagerstown Md. Date signed 12/22/45

104

12775

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Rural Near Cearfoss Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Near Cearfoss
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hagerstown Rt. 4
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George S. Keener

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Eliza R. Keener
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 27, 1859

8. AGE: Years	Months	Days	If less than one day
86	9	9	....hrs. ....min.

9. Birthplace: Lanchester County Pa.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: George S. Keener
13. Birthplace: Germany

MOTHER
14. Maiden name: Fannie Stouffer
15. Birthplace: Germany

16. Informant: Clinton J. Keener
Address: Hagerstown Rt. 4

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 9, 1945 (month) (day) (year)
Cemetery or crematory: Reiff Mennonnite
Location: Near Cearfoss Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstwon Md.

19. Dec. 8 (Date rec'd by registrar) 19 45 Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6 19 45, at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 - 19 45 to Dec 6 - 45
and that I last saw him alive on Dec 6 - 45 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 Days
Due to: Cerebral Sclerosis	
Due to: Pneumonia Left	5 Wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: F W Cullo M. D. or other
Address: Hagerstown Md Date signed 12/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Bell 122

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

12776

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Funkstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Years

Hospital, Institution, or street address where death occurred:

East Baltimore St.

How long in hospital or Institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Funkstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. East Baltimore St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME William Henry Kershner

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Susan

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) July 31 1875

8. AGE: Years	Months	Days	If less than one day
70	2	15	....hrs. ....min.

9. Birthplace Fairview Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Overseer

11. Industry or business State Road

FATHER 12. Name Jacob S. Kershner

13. Birthplace Marlowe W. Va.

MOTHER 14. Maiden name Susan Chrisman

15. Birthplace Williamsport Md.

16. Informant John L. Kershner

Address Hagerstwon Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Dec. 18. 1945 Elsie M. Bovard, Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1945 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9. 1945 to Dec. 16. 1945

and that I last saw him alive on December 16. 1945

Immediate cause of death	DURATION
Cerebral Apoplexy	7 days
Due to Hypertension & Arteriosclerosis	2 yrs
Due to	
Other conditions Carcinoma of Rectum	8 months

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. A. Beel M. D. ~~or other~~

Address Hagerstown, Md. Date signed 12/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Bell

12777

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washin gton

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? IO Days

Hospital, Institution, or street address where death occurred:
Washington Co. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2I West Antietam St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs Carrie E. King

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Samuel L.

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): June 2I I872

8. AGE: Years	Months	Days	If less than one day
73	6	7	....hrs. ....min.

9. Birthplace: Shepherdstown Jefferson W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: George Show
13. Birthplace: Shepherdstown W. Va.

MOTHER
14. Maiden name: Henrette Orndorff
15. Birthplace: Shepherdstown W. Va.

16. Informant: Samuel L. King
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: I2/3I/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec. 30. 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

P. M.

20. DATE OF DEATH: December 28 1945 at I2:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1945, to Dec. 28, 1945 and that I last saw her alive on December 28, 1945

Immediate cause of death	DURATION
Fractured clavicle, right.	13 days
Due to	
Due to	
Other conditions Pulmonary embolism	15 mins.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Auto accident Date of: Dec. 15. 1945

Where did injury occur? New Bedford (City or town) (x) (County) Pa. (State)

Injured at home, farm, industry, public place (where?): Public highway.

Means of injury: Auto skidded off road. Injured at work? No.

23. SIGNATURE: L. A. Bell M. D. or other

Address: Hagerstown Md. Date signed: 12/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

12778

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, Institution, or street address where death occurred:
Penn. Round House

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 140 West Antietam Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George H. Kitzmiller, Sr.

3.(b) Social Security Number: 214-09-1947

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Pearl Kitzmiller

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): September 8, 1881

8. AGE: Years	Months	Days	If less than one day
64	3	11	hrs. min.

9. Birthplace: Harrisburg, Pa.
(Town, county, and state)

10. Usual occupation: Crew Dispatcher

11. Industry or business: Penn. Railroad

FATHER
12. Name: Benjamin Kitzmiller
13. Birthplace: Harrisburg, Pa.

MOTHER
14. Maiden name: Katherine Maxwell
15. Birthplace: Harrisburg, Pa.

16. Informant: Mrs. Geo. H. Kitzmiller, Sr.
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Dec - 21 19 45 (Date rec'd by registrar) C. Earl Beavers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 45 19 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15-45 19 to Dec 19-45 19 and that I last saw ~~him~~ alive on Dec 18-45 19

Immediate cause of death	DURATION
Coronary Thrombosis	4 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. W. Suter M. D. or other

Address: Hagerstown Md Date signed 12/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

1279

Reg. Dist. No. 302

1. PLACE OF DEATH

County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 2 days

Hospital, institution, or street address where death occurred: Washington Co Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown Md RD1 (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Naomi Ruth Kline

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 12-9-1944

8. AGE: Years — Months — Days: 2 — If less than one day: — hrs. — min.

9. Birthplace: Washington Co Hospital (town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: James R. Kline

FATHER — 13. Birthplace: Fred Co. Md

MOTHER — 14. Maiden name: Naomi E. Williams

MOTHER — 15. Birthplace: Near Smithsburg Md

16. Informant: James R. Kline

Address: Hagerstown R-F-D-1

17. Burial, cremation, removal. Which? Burial Date thereof: 12-12-1945 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant

Location: Near Pleasant Valley

18. Funeral director: Geo B Hoover

Address: Smithsburg Md

19. Dec. 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 1945, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1945 to Dec 11 1945 and that I last saw h... alive on Dec 11 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 hrs.
Due to: not determined	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: G. C. Hooker M. D. or other

Address: Smithsburg Md Date signed: 12/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

12789

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:
County: Washington
City or town: Rural-Sharpsburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural--Antietam
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clarence M. Kretzer

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nannie Kretzer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 4, 1891

8. AGE: Years	Months	Days	If less than one day
54	8	5	hrs. min.

9. Birthplace: Anitietm--Wash.--Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: George Kretzer
13. Birthplace: Anitietam, Maryland

MOTHER
14. Maiden name: Annie Otzelberger
15. Birthplace: Antietam, Maryland

16. Informant: Mrs. Nannie Kretzer
Address: Rural--Sharpsburg, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12--11--1945 (month) (day) (year)
Cemetery or crematory: Mt. View
Location: Sharpsburg, Maryland
18. Funeral director: R. I. Earnshaw
Address: Keedysville, Maryland

19. 12/10 19 45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 9 19 45, at 2:45 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 8 19 45, to Dec. 9 19 45, and that I last saw h alive on Dec. 9 19 45

Immediate cause of death	DURATION
(a) Coronary occlusion	2 hrs.
Due to (b) Pernicious hypertension & arteriosclerosis	6 yrs.
Due to (c)	
Other conditions: Mild diabetes mellitus	?

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter H. Shealy M.D.
M. D. or other
Address: Sharpsburg, Md. Date signed: 12/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Porterfield

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

12781

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Week
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 807 Mulberry Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Addis U. Leatherman

3.(b) Social Security Number: 216-14-5348

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widower

6.(b) Name of husband or wife: Amanda
6.(c) If alive, give age: -
7. Birth date of deceased (mo., day, yr.): May 26 1873

8. AGE: Years	Months	Days	If less than one day
72	6	7	hrs. min.

9. Birthplace: Church Hill Fred. Co. Md. (Town, county, and state)
10. Usual occupation: Messenger
11. Industry or business: Second Natl. Bank
FATHER 12. Name: Josiah Leatherman
13. Birthplace: Church Hill Md.
MOTHER 14. Maiden name: Sarah Snyder
15. Birthplace: Church Hill Md.
16. Informant: Albert G. Leatherman
Address: Catonsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/5/45 (month) (day) (year)
Cemetery or crematory: Rose Hill cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Dec. 5 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1945 at 7.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1945 to Dec. 3 1945 and that I last saw h. i. m. alive on Dec. 3 1945

Immediate cause of death	DURATION
Coronary Occlusion (Thrombosis)	7 hrs.
Due to	
Due to	
Other conditions: Inguinal Hernia, operative repair of (Include pregnancy within 3 months of death)	1 wk

Major findings of operations: Inguinal Hernia, indirect Right. Date of op. Nov. 26, 1945
Autopsy results: None done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Richard V. Hoover M.D. M. D. or other
Address: Hagerstown, Md. Date signed: Dec. 4 '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of date of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-O)

12782

FILM No. I 00 JAN 8 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 years

Hospital, Institution, or street address where death occurred:
236 Summit Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 236 Sumitt.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jacob A. Lorshbaugh

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 12, 1871.

8. AGE: Years	Months	Days	If less than one day
74	9	000	hrs. min.

9. Birthplace: Washington, Maryland
(Town, county, and state)

10. Usual occupation: Retired Butcher.

11. Industry or business

FATHER — 12. Name: Jacob Lorshbaugh Sr.

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary McCarty

15. Birthplace: Maryland

16. Informant: Robert Wolfe

Address: Hagerstown,

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown

19. Dec 22, 1945 (Date rec'd by registrar) C Kart Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20, 1945 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 45 to Dec 7 1945

and that I last saw him alive on Dec 7 1945

Immediate cause of death: Nephritis Chronic Interstitial — DURATION: 1 yr

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: N.O

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. M. Alley Brown M. D. or other

Address: 164 W. Wash Date signed 12-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

* 12783 302

Reg. Dist. No.

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 2 days & 6 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 115 East Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph H. Lowery

3.(b) Social Security Number: 215-18-1681

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence Lowery

6.(c) If alive, give age: years

7. 9irth date of deceased (mo., day, yr.): Febuary, 19, 1872

8. AGE: Years	Months	Days	If less than one day
73	10	10	hrs. min.

9. 9irthplace: Washington, Maryland.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Sheet Metal Worker

FATHER 12. Name: John Lowery

FATHER 13. 9irthplace: Pennsylvania.

MOTHER 14. Maiden name: Nanda Ellen Beatty

MOTHER 15. 9irthplace: Pennsylvania

16. Informant: Mrs. Florence Lowery

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 1, 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland.

18. Funeral director: F. W. Kraiss

Address: Hagerwtown, Maryland.

19. Dec. 31 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION P. M. 6m

20. DATE OF DEATH: December 29 1945 at 6m M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 1945 to 12/29 1945 and that I last saw h. alive on 12/29 1945

	DURATION
Immediate cause of death: Intestinal Obstruction	10 hours
Due to: Carcinoma of Sigmoid	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: as above. —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Victor D. Miller M. D.

DR. VICTOR D. MILLER

Address: 131 W. WASHINGTON, ST. Date signed: 12-29-45

HAGERSTOWN, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

12784

★ Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20Yrs.
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or Institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 36 Elizabeth St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Florence L. Lowman

3.(b) Social Security Number: 214-09-5509

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 23, 1898

8. AGE: Years	Months	Days	If less than one day
47	6	23	..... hrs. ..... min.

9. Birthplace: Chewsville Md. (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER
12. Name: Frank Lowman
13. Birthplace: Leitersburg Md.

MOTHER
14. Maiden name: Jennie McCauley
15. Birthplace: Chewsville Md.

16. Informant: Mrs. Ruby Castle
Address: Williamsport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-19-45 (month) (day) (year)
Cemetery or crematory: Greenlawn
Location: Williamsport Md.

18. Funeral director: C.M. Suter & Sons
Address: Hagerstown Md.

19. Dec. 18. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/6/45 19.. at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-30-45 19.. to 12/6/45 19.. and that I last saw h.. alive on 12/6/45 19..

	DURATION
Immediate cause of death: Cerebral Apoplexy	immediate
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: C. F. Young M. D. or other
Address: Williamsport Md. Date signed: 12/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(186-a)

Dr. Novenstein

12783

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, institution, or street address where death occurred: Washington Co. Hospital

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Western Pike

(If outside city or town limits, write RURAL and give nearest town)

Street No. Gateway Nurseing Home

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs Ida M. Ludy

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Cyrus M.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. I4 I868

8. AGE: Years	Months	Days	If less than one day
77	I0	I5	..... hrs. ..... min.

9. Birthplace: Wolfesville Fredrick Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: James A. Grove

13. Birthplace: Wolfesville Md.

MOTHER

14. Maiden name: Hairett Hays

15. Birthplace: Wolfesville Md.

16. Informant: James L. Ludy

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof I/I/46 (month) (day) (year)

Cemetery or crematory: U.B. Cemetery

Location: Myersville, Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Jan. 1. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1945 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Dec. 29. 1945 and that I last saw h.. alive on Dec 29 1945

Immediate cause of death	DURATION
Bronchitis & Bronco-Pneumonia	dec 10-45
Due to	
Due to Fracture Right femur,	dec 9-45
Other conditions Due to Accidental fall. Arteriosclerosis	

Syphilis Leukema

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of December 9th, 1945

Where did injury occur? Hagerstown, Route #2, Washington, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Laymans Nursing Home

Means of injury Accidental fall. Injured at work?

23. SIGNATURE: Sidney Novenstein M.D.

M. D. or other

Address: Hagerstown Md Date signed 12-30-45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 11

CERTIFICATE OF DEATH

12780

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 722 West Church St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 722 West Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Manious

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 11, 1868

8. AGE: Years	Months	Days	If less than one day
77	9	15	..... hrs. ..... min.

9. Birthplace: Hagerstown, Washington, Md.
(Town, county, and state)

10. Usual occupation: Retired Railroad Conductor

11. Industry or business

FATHER
12. Name: John Manious
13. Birthplace: Lancaster, Penna.

MOTHER
14. Maiden name: Indinia Eickelberger
15. Birthplace: Maryland.

16. Informant: William C. Manious
Address: Hagerstown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery.
Location: Hagerstown, Maryland.

18. Funeral director: F. W. Kraiss
Address: Hagerstown, Maryland.

19. Dec 28 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26, 1945 12:00 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan — 19 45 to Dec 26 19 45
and that I last saw h... alive on Dec 22 19 45

Immediate cause of death	DURATION
Pneumonia	10 days
Due to Arteriosclerosis	
Due to Enlarged Prostate	5 Years
Other conditions Diabetes Mellitus	—

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Harry Bowers M.D. M. D. or other
Address: Hagerstown Md. Date signed 12/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12787

Reg. Dist. No. 304

1. PLACE OF DEATH:

County: Washington

City or town: Hancock Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hancock, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Donald Edward Mann

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 13 1945

8. AGE: Years	Months	Days	If less than one day
0	0	18	hrs. min.

9. Birthplace: Hancock, Rural (Town, county, and state)

10. Usual occupation: Infant.

11. Industry or business

FATHER — 12. Name: Espey Mann

FATHER — 13. Birthplace: Washington Co.

MOTHER — 14. Maiden name: Margret Flowers

MOTHER — 15. Birthplace: Washington Co.

16. Informant: Mr. Espey Mann

Address: Hancock, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2 1946 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: West of Hancock, Route 40

16. Funeral director: Snyder-Rowland

Address: Hancock, Md.

January 1 19 46 J. M. Steller

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 19 45 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 19 45 to Dec 31 19 45 and that I last saw h~~im~~ alive on Dec 31 19 45

Immediate cause of death	DURATION
Congenital Heart	
Due to: Malnutrition	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B. M. Shaffer MD M. D. or other

Address: Hancock Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

12788

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:
542 North Mulberry Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 542 North Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Ross Markley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Albina Markley

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): July 3, 1890

8. AGE:	Years	Months	Days	If less than one day
	55	5	25	hrs. min.

9. Birthplace: Croos Road, Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Wholesale Produce

11. Industry or business: Own Business

FATHER
12. Name: John M arkley
13. Birthplace: Baltimore Co. Md

MOTHER
14. Maiden name: Lear C. Dixon
15. Birthplace: Baltimore Co. Md

16. Informant: Mrs. John R. Markley
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-31-45 (month) (day) (year)

Cemetery or crematory: Mapleville, Cemetery

Location: Mapleville, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Dec. 30, 1945 (Date rec'd by registrar) Clark H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28, 1945. at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27, 1945 to Dec. 28, 1945 and that I last saw him alive on December 27, 1945

Immediate cause of death	DURATION
Coronary Occlusion	9 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. R. Markley M. D. or other

Address: 148 W. Washington St. Date signed 12/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (200-B)

CERTIFICATE OF DEATH

1278

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo.

Hospital, Institution, or street address where death occurred:

Clair Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Clair Street.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert L. ~~Mc Cinzgo~~ Mazingo

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 26, 1945

8. AGE: Years	Months	Days	If less than one day
	2	9	..... hrs. ..... min.

9. Birthplace: Hagerstown, Washington, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Charles ~~Mc Cinzgo~~ Mazingo

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Dora Hensley

MOTHER — 15. Birthplace: Virginia

16. Informant: Charles ~~Mc Cinzgo~~ Mazingo

Address: Hagerstowm, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 7, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Hancock Maryland.

18. Funeral director: Snyder - Rowland

Address: Hancock, Maryland.

19. Dec. 6 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5, 1945 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from never attended 19..... to ..... 19.....

and that I last saw h.m. alive on Dec 2 1945

Immediate cause of death: Dont Know Child was found dead in bed

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm Allan Brown M. D. or other

Address: 164 W Wash Date signed: Dec 6 45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

127911

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wash.
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles L. McAfee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Feb 22, 1860

8. AGE: Years	Months	Days	If less than one day
85	9	19	hrs. min.

9. Birthplace: Mercersburg, Pa
(Town, county, and state)
10. Usual occupation: N. & N.C.
11. Industry or business: —
12. FATHER — Name: Thomas McAfee
13. FATHER — Birthplace: Pa.
14. MOTHER — Maiden name: Elizabeth Reed McAfee
15. MOTHER — Birthplace: Pa
16. Informant: Mrs. Ella Mae Hockman
Address: Hancock, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15, 1945 (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Mercersburg, Pa
18. Funeral director: Charles R. Bast
Address: Hancock, Md.
19. Dec. 14, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 DEC 1945 at 11:59 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 DEC 1945 to 12 DEC 1945 and that I last saw him alive on 12 DEC 1945

Immediate cause of death	DURATION
UREMIA	2 WEEKS
Due to: PROSTATIC HYPERTROPHY, WITH ASSOCIATED RENAL MALFUNCTION	?
Due to:	
Other conditions: SENILITY	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William D. Layman, M.D.
M. D. or other
Address: 100 PROFESSIONAL ARTS BLDG HAGERSTOWN, MD. Date signed: 14 Dec '45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

1279₁

Reg. Dist. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Rural Hagerstown Route 40 W
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Gateway Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Franklin

City or town: Chambersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Carrie E. McAran

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Patrick McAran

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Born March 3, 1882

8. AGE: Years	Months	Days	If less than one day
63	9	11	hrs. min.

9. Birthplace: Fort Loudon, Pennsylvania (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER — 12. Name: John Rogrut

FATHER — 13. Birthplace: -------- Pa.

MOTHER — 14. Maiden name: Elizabeth Irisman

MOTHER — 15. Birthplace: -------- Pa.

16. Informant: Mr. Layman

Address: Gateway Nursing Home

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 17, 1945 (month) (day) (year)

Cemetery or crematory: Corpus Christi

Location: Chambersburg, Pa.

18. Funeral director: Fred. W. Kraiss

Address: Hagerstown, Md.

19. Dec. 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13, 1945 3:00 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 19 45 to Dec 14 19 45

and that I last saw her alive on Dec 14 19 45

Immediate cause of death	DURATION
Cerebro-sclerosis — generalized	
Due to	
Due to	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Sidney Loverstein MD M. D. or other

Address: Chambersburg Md Date signed 12-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12792

Reg. Dist. No. 316

Dr. young.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS-A15 9-45-1

1. PLACE OF DEATH:
County Washington
City or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
Main St.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Otho Augustus McCoy.

3. (b) Social Security Number 213-16-0123

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Mary Elizabeth McCoy
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January - 7 - 1897

8. AGE: Years	Months	Days	If less than one day
48	11	1	..... hrs. ..... min.

9. Birthplace Sharpsburg Wash. Co. Md. (Town, county, and state)
10. Usual occupation Track Man
11. Industry or business B. & O. R.R.

FATHER
12. Name Alonzo McCoy
13. Birthplace Sharpsburg Wash. Co. Md.

MOTHER
14. Maiden name Arena Marshall
15. Birthplace Sharpsburg Wash. Co. Md.

16. Informant Mrs. Mary Hammond
Address Keedysville Md.

17. Burial. Date thereof December 12, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Samples Manor Cemetary
Location Samples Manor Md.

18. Funeral director Wm. J. Bast & Sons
Address Boonsboro Md.

19. Dec 10 1945 R. A. Greetter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8/45 19 ..... at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/6/45 19 ..... to 12/8/45 19 .....
and that I last saw him alive on 12/8/45 19 .....

Immediate cause of death	DURATION
Coronary Occlusion	1 Day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. L. Young M. D. or other
Address Williamsport, Md. Date signed 12/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-2)

CERTIFICATE OF DEATH

12793

12

Reg. Diat. No. 307

1. PLACE OF DEATH:

County Washington

City or town Chestnut Grove - 'Rural'
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Keedysville md. R. 1

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Chestnut Grove 'Rural'
(If outside city or town limits, write RURAL and give nearest town)

Street No. Keedysville md. R. 1
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Daniel Leo. Mety

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April - 9 - 1945

8. AGE: Years ..... Months 8 Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace Chestnut Grove Wash. Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business at Home.

MOTHER FATHER

12. Name Charles S. Mety

13. Birthplace Chestnut Grove. Wash. Co. Md.

14. Maiden name Catherine Springer

15. Birthplace Chestnut Grove Wash. Co. Md.

18. Informant Charles S. Mety

Address Keedysville md. R.1

17. Burial, (Burial, cremation, or removal. Which?) Date thereof December - 13 - 1945 (month) (day) (year)

Cemetery or crematory Samples Manor Cemtay

Location Samples manor md.

18. Funeral director Wm. J. Boat & Sons

Address Boonsboro md.

19. Dec. 13 1945 (Date rec'd by registrar) Mrs. Katherine Dagenhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1945, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Birth 19.. to Dec. 11 1945 and that I last saw him alive on Dec. 8 1945

Immediate cause of death Congenital Heart disease — DURATION life

Due to Genito-fermental anomalies

Due to

Other conditions Cleft palate, Ingrined & umbilical Hernias, Grippe (1 week)
(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Walter H. Shealy M.D.
M. D. or other

Address Sharpsburg, Md. Date signed 12/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12794

Reg. Diat. No. 305

Dr. Le Vain.

M

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15

1. PLACE OF DEATH:

County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr.

Hospital, institution, or street address where death occurred: Lakin Ave.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Locust Grove, (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Keedysville Md. R.1

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Daniel Gaines Miller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ada Miller

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November -1- 1870

8. AGE:	Years	Months	Days	If less than one day
	75	1	7	..... hrs. ..... min.

9. Birthplace: near Rohersville Wash. Co. Md.

(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER 12. Name: Joshua Miller

FATHER 13. Birthplace: near Keedysville Wash. Co. Md.

MOTHER 14. Maiden name: Amanda E. Shifler

MOTHER 15. Birthplace: near Rohersville Wash. Co. Md.

16. Informant: Daniel J. Miller

Address: Keedysville Md. R.1

17. Burial. Date thereof: December 11. 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetary

Location: Boonsboro Md.

16. Funeral director: Wm. D. Bast & Sons

Address: Boonsboro Md.

18. Dec. 10 1945 John H. Bast

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1945 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8 1945 to December 8 1945

and that I last saw him alive on December 8 1945

Immediate cause of death	DURATION
Angina Pectoris	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. W. Lillan M. D.

M. D., or other

Address: Boonsboro Date signed: 12/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-P)

CERTIFICATE OF DEATH

12795

Reg. Dist. No. 3021

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Peggy Joann Peck

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16, 1945

8. AGE:	Years	Months	Days	If less than one day
	0	3	16	hrs. min.

9. Birthplace Hancock, Wash. Co., Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Frederick Peck
13. Birthplace Warfordsburg, Pa.

MOTHER
14. Maiden name Margaret Fling
15. Birthplace Hancock, Md.

16. Informant Frederick Peck,
Address Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4-45 (month) (day) (year)

Cemetery or crematory River View Cemetery

Location Hancock, Md.

18. Funeral director Snyder-Rowland Funeral Home

Address Hancock, Md.

19. Dec. 4. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1945 19 at 9 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 18 1945 to Dec 1 1945

and that I last saw her alive on 12/1 1945

Immediate cause of death	DURATION
(a) Intussusception	
Due to	
Due to	
Other conditions Premature	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Intussusception

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Bowman M.D.
M. D. or other

Address Hagerstown, Md. Date signed 12/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Novenstein

141

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

12796

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, institution, or street address where death occurred:
Dual Highway

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. Dual Highway
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: David Elmer Reid

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): November 24 1855

8. AGE: Years	Months	Days	If less than one day
90	1	2	...hrs. ...min.

9. Birthplace: Broadfording Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: William P. Reid
13. Birthplace: Broadfording Md

MOTHER
14. Maiden name: Mary E. Schamel
15. Birthplace: Broadfording Md.

16. Informant: Mrs. Renner Brewer
Address: Hagerstown Md. # 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/28/45 (month) (day) (year)
Cemetery or crematory: Manor Cemetery
Location: near Tilghmanton Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Dec. 26. 1945 (Date rec'd by registrar) Chas. H. Boyer Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: December 26 1945 19..., at 1 ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 19.45, to Dec. 26 19.45
and that I last saw h[illegible] alive on Oct 26 19.45

Immediate cause of death	DURATION
Generalized arterio-sclerosis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Sidney Novenstein M.D.
M. D. or other

Address: Funkstown Md. Date signed 12-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12797

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 636 Highland Way
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 636 Highland Way
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Francis E. Renner

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1870

8. AGE: Years 75 Months 11 Days 24 If less than one day: hrs. min.

9. Birthplace: Hagerstown, Washington, Md. (town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Elias Renner
13. Birthplace: Maryland

MOTHER 14. Maiden name: Mollie Ambrose
15. Birthplace: Maryland

18. Informant: Mrs. W. H. Roane
Address: Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown

18. Funeral director: Fred W. Kraiss.
Address: Hagerstown

19. Dec. 28 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION 4"15

20. DATE OF DEATH: Dec 23 1945 at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1930, to Dec. 23 1945
and that I last saw h.. alive on Dec. 20 1945

Immediate cause of death	DURATION
Chronic Myocarditis	15 years
Coronary Thrombosis	1/2 hr.
Due to: Senility & arter-sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. Carbaugh M. D. or other
Address: Hagerstown Md. Date signed: Dec. 26 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

90

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120-a)

12798

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington Co.

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks

Hospital, institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Franklin

City or town: Greencastle R.R. 3

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. R. 3

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Dorothy Marie Rice

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: Melvin Rice

8.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): October 14, 1924

8. AGE: Years	Months	Days	If less than one day
21	1	18	..... hrs. ..... min.

9. Birthplace: Greencastle, R. R.3 (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Merle E. Spangler

FATHER — 13. Birthplace: Chambersburg, R.R. 5

MOTHER — 14. Maiden name: Ruth A. Kline

MOTHER — 15. Birthplace: Maugansville, Md.

16. Informant: Melvin Rice

Address: Greencastle, R.R.3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/4/1945 (month) (day) (year)

Cemetery or ~~crematory~~: Shank's Church

Location: Greencastle, R.R. 3

18. Funeral director: Walter Y. Gunn

Address: 276 Church St. Waynesboro, Pa.

19. Dec. 3 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1945, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14 1945, to Nov. 1 1945 and that I last saw h.. alive on November 30 1945

Immediate cause of death	DURATION
Uremia (Terminal disease - Fistula formation)	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Resection bladder with fistulae formation. Date of op. 11/20/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of 11

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner

Address: Hagerstown, Md. Date signed: 12/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12799

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:
32 Kramers Alley
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wash.
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 32 Kramers Alley
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3. (a) FULL NAME: Bessie Lee Rider

3. (b) Social Security Number: - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: George Rider
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 15, 1883

8. AGE:	Years	Months	Days	If less than one day
	62	4	4	hrs. min.

9. Birthplace: Hagerstown, Wash., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Manuel Boward
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Ella May Springer
15. Birthplace: Rhorersville, Md.

16. Informant: Mrs. Gertrude C. Orcutt
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown, Md.

19. Dec-21-1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19, 1945, at 9:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to Dec 1945
and that I last saw her alive on Dec 1945

Immediate cause of death	DURATION
Pulmonary regurgitation	1 Yr
Due to	
Due to	
Other conditions: Bronchitis	2 Wk

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D.
Address: [illegible] Date signed: Dec 20 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

137

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46a/k

CERTIFICATE OF DEATH

128(11) 302

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred: Washington Co. Hospital

How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 W. Bethel Street

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME George Edward Robinson

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Divorced

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11/17/1900

8. AGE: Years	Months	Days	If less than one day
45	1	8	..... hrs. ..... min.

9. Birthplace Hagerstown (Town, county, and state)

10. Usual occupation Bartender

11. Industry or business .....

FATHER 12. Name William H. Robinson

13. Birthplace .....

MOTHER 14. Maiden name Katie Williams

15. Birthplace .....

16. Informant .....

Address .....

17. Burial (Burial, cremation, or removal) Which?) Date thereof 12/26/45 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown Md.

18. Funeral director Hart & Spinner

Address 291 Frederick St Hagerstown

19. Dec. 26. 1945 Chas H Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1945 at 2:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 1945 to Dec. 23 1945

and that I last saw him alive on Dec. 23 1945

Immediate cause of death	DURATION
Asphyxiation	
Due to Tumor of the esophagus	
Due to Probably malignant	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Microscopic tumor of esophagus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Walter Seymour M.D. M. D. or other

Address Hagerstown Md. Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

#7

12811

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington County
City or town Williamsportk Maryland
(If outside city or town limits, write RURAL and give nearest towo)
How long in above place of death? 66 yrs.
Hospital, institution, or street address where death occurred:
Williamsport, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport,
(If outside city or town limits, write RURAL and give nearest town)
Street No. Fredrick St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel Scott Robinson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sara Catherine Robinson deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 14 1858

8. AGE: Years	Months	Days	If less than one day
87	2	3	hrs. min.

9. Birthplace: Fourt Louden Pa. (Town, county, and state)

10. Usual occupation: Western Maryland Rail Road

11. Industry or business: Forman Section

FATHER
12. Name: Davis Robinson
13. Birthplace: Burnt Cabins, Pa.

MOTHER
14. Maiden name: Harriet Bungardner
15. Birthplace: Burnt Cabids, Pa.

16. Informant: Stella Grove
Address: Williamsport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20 1945 (mooth) (day) (year)

Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Md.

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport Md.

19. Dec. 20 1945 (Date rec'd by registrar) Mrs E. Le McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17 1945, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 1945, to Dec 17 1945 and that I last saw h.. alive on Dec. 16, 45 1945

Immediate cause of death	DURATION
Myocardial's Chronic	17 days
Due to	
Chronic Nefritis	2 Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Williamsport Md. Date signed 12/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Kneisley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12802 Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Chewsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred:
Chewsville - Whitehall Rd.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Chewsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chewsville-Whitehall Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Bertie /Lenore Ruch

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William H.
6.(c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): December 25 1876

8. AGE: Years	Months	Days	If less than one day
68	11	12	....hrs. ....min.

9. Birthplace: Chewsville Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Jacob Echstine
FATHER 13. Birthplace: Chewsville Md
MOTHER 14. Maiden name: Maria Lechrone
MOTHER 15. Birthplace: Waynesboro Pa.
16. Informant: William H. Ruch
Address: Smithsburg Md R #2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/45 (month) (day) (year)
Cemetery or crematory: Mausoleum
Location: Smithsburg Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Dec. 8. 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7 1945 19.... at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25 1945 to December 6 19 45 and that I last saw her alive on Dec. 6. 1945 19....

Immediate cause of death	DURATION
Chronic myocarditis with congestive failure	13 months
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: B B Blenkinsop M.D. M. D. or other
Address: 148 W. WashingtonSt., Date signed: 12/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

106

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

12813 302

Reg. Dist. No. ....

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 70 West Franklin Street
(If rural, give LOCATION)

2.(a) If veteran, name war ....

3. (a) FULL NAME John Russell

3. (b) Social Security Number 220-01-5283

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife Effie Russell

B.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 58			....hrs. ....min.

9. Birthplace Shippensburg, Pa.
(Town, county, and state)

10. Usual occupation ....

11. Industry or business Fairchild Corp.

FATHER
12. Name John Russell
13. Birthplace Not Known

MOTHER
14. Maiden name May -------
15. Birthplace Not Known

16. Informant Mrs. Lillian Artz

Address Stroudsburg, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-11-45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Dec 10, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH D.C. 1945 at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 6 1945

and that I last saw h.... alive on Dec 6 1945

Immediate cause of death Coronary Thrombosis — DURATION 4 days

Due to ....

Due to ....

Other conditions ....

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....

Autopsy results W.D.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE W. Allan Brown M. D. or other

Address 162 W Wash St Date signed Dec 10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186)

CERTIFICATE OF DEATH

Reg. Dist. No. 12814 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 318 North Mulberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William E. Schwinger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Bessie Schwinger
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 8, 1877

8. AGE:	Years	Months	Days	If less than one day
	68	2	8	____ hrs. ____ min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Glove Cutter
11. Industry or business:

FATHER
12. Name: John Schwinger
13. Birthplace: Not Known

MOTHER
14. Maiden name: Maria Smith
15. Birthplace: Germany

16. Informant: Blanche Schwinger
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-20-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Dec. 18. 1945 (Date rec'd by registrar) Chas. H. Board, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16- 45 19____ at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5- 19 45 to Dec 16- 1945 and that I last saw ~~him~~ alive on Dec 16-45 19____

Immediate cause of death	DURATION
(a) Fracture femur	11 day
Due to	
Due to (b) Chr. Myocarditis	6 Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide~~, or homicide: ____ Date of 12/16/45
Where did injury occur? Hagerstown Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Fell on ice. Injured at work? no

23. SIGNATURE: W. E. Schwinger M. D. or other
Address: Hagerstown Md Date signed 12/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-C)

CERTIFICATE OF DEATH

12805

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Fulton
City or town: Amaranth
(If outside city or town limits, write RURAL end give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Adam Shank

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy Shank
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 21, 1913

8. AGE: Years	Months	Days	If less than one day
32	2	12	..... hrs. ..... min.

9. Birthplace: Fulton County, Pa. (Town, county, and state)
10. Usual occupation: School Bus Driver and
11. Industry or business: Farmer

FATHER
12. Name: George A. Shank
13. Birthplace: Fulton County, Pa.

MOTHER
14. Maiden name: Blanch Wallice
15. Birthplace: Clearfield, Pa.

16. Informant: Mrs. Dorothy Shank
Address: Amaranth, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1945 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Amaranth, Pa.

18. Funeral director: Snyder-Rowland Funeral Home
Address: Hancock, Md.

19. DEC. 5 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3, 1945 19.. at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..
and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Fracture dislocation	
Due to: of 4 & 5th cervical	
vertebra	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 12/2/45
Where did injury occur? 1/4 miles west Hancock (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Route 40 - Highway
Means of injury Auto accident Injured at work? MEDICAL EXAM. DEPT. WASH. CO., MD.

23. SIGNATURE J. Rubin B. Wells M. D. or coroner
Address: Hagerstown, Md. Date signed 12/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

220-09-9095

Dr. Bell 12806 112

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore (191-G)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days

Hospital, Institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 425 Guilford Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Oliver McCluster Smith

3. (b) Social Security Number: 220-09-9095

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 11 1881

8. AGE: Years	Months	Days	If less than one day
64	8	1	...hrs. ...min.

9. Birthplace: Myersville Fred. Co. Md.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Park Circle Tavern

FATHER
12. Name: Hiram T. Smith
13. Birthplace: Middletown Md.

MOTHER
14. Maiden name: Laura A. Dutrow
15. Birthplace: Myersville Md.

16. Informant: Mrs. Anna Smith
Address: Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/14/45 (month) (day) (year)

Cemetery or crematory: United Brethern Cemetery

Location: Myersville Md.

18. Funeral director: Andrew K: Coffman

Address: Hagerstown Md.

19. Dec 14 19 45 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: December 12 1945 19... at 8.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27, 19 45, to Dec. 12, 19 45 and that I last saw h. alive on December 11, 19 45

Immediate cause of death	DURATION
Virus Pneumonia	10 days
Due to	
Due to	
Other conditions Hypertension cardio-vascular renal disease	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation ...Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R A Bell M. D. or other

Address: Hagerstown Md. Date signed 12/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

A15

144

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46) K

CERTIFICATE OF DEATH

128 17

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 57 Wsetside Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 57 Westside Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth Estey Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1893

8. AGE: Years	Months	Days	If less than one day
52	9	7	hrs. min.

9. Birthplace: Smithburg, Washington, Md. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Daniel Souders
13. Birthplace: Maryland

MOTHER
14. Maiden name: Charlott Stoner
15. Birthplace: Penna.

16. Informant: Harry V. Smith, Jr.
Address: 218 Simmit Ave. Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 29, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: F. W. Kraiss
Address: Hagerstown, Md.

19. Dec-28 1945 (Date rec'd by registrar) Chas H Boovers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25, 1945 19 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 24 19 45 to Dec 25 19 45 and that I last saw her alive on Dec 25 19 45

Immediate cause of death	DURATION
Circulatory failure	
Due to: Pneumonia	
Due to: Gastric Cancer	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter Lippman M.D. M. D. or other
Address: Hagerstown Md. Date signed: 12/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

12818 #7

Reg. Dist. No. 38-

1. PLACE OF DEATH:

County Washington County

City or town Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
109 W Potomac St Williamsport, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 W. Potomac St.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence Alfred Snyder

3.(b) Social Security Number 215-01-9966

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 5 1877

8. AGE: Years	Months	Days	If less than one day
68	9	20	..... hrs. ..... min.

9. Birthplace Williamsport, Md.
(Town, county, and state)

10. Usual occupation Labor

11. Industry or business Byrons Tannery

FATHER 12. Name Christian S Snyder

13. Birthplace Williamsport Md.

MOTHER 14. Maiden name Susan Connor Snyder

15. Birthplace Clearspring Md.

16. Informant Mrs. Elva Grove (sister)

Address 109 W Potomac St. Williamsport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29 1945 (month) (day) (year)

Cemetery or crematory Riverview Cemetery

Location Williamsport, Md.

18. Funeral director Edith V Leaf

Address #7 Church St. Williamsport, Md.

19. Dec 29 1945 (Date rec'd by registrar) Mrs. E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 25 1945, to Dec. 25 1945 and that I last saw h.im alive on Dec. 25 '45 1945

Immediate cause of death	DURATION
Cardiac dilation	1 hour.
Due to	
Due to Myocarditis Chronic	1 year.
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE [signature] M. D. or other

Address Williamsport Md. Date signed 12/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

Dr. Wells

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? II Years

Hospital, Institution, or street address where death occurred:
103 ~~West~~ East Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 East Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: William Chester Spielman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Edna L.B.

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): May 3 I885

8. AGE: Years	Months	Days	If less than one day
60	7	24	...hrs. ...min.

9. Birthplace: Hagerstown Washington Md.
(Town, county, and state)

10. Usual occupation: Parcel Post

11. Industry or business: U.S. Post Office

FATHER
12. Name: James Spielman
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Annie Lushbaugh
15. Birthplace: Hagerstown Md.

16. Informant: Mrs Edna B. Spielman
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/30/45 (mont.) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

16. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Dec. 30, 1945 (Date rec'd by registrar) Elsie H Boarer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: De c/27/45 19... at 7:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
chr. myocarditis	lyr
Due to: acute coronary occlusion	5hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: no ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A Robert Wells
DEPUTY MEDICAL EXAM
WASH. CO., MD.

M. D. or ~~other~~

Address: Hagerstown Md, Date signed 12/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12810302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, Institution, or street address where death occurred:
1922 Virginia Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1922 Virginia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha Virginia Sprecher

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Fred O. Sprecher
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 25, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	8	16	...hrs. ...min.

9. Birthplace: Wash. Co., Md. (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business

FATHER
12. Name: George W. Sprecher
13. Birthplace: Wash. Co., Md.

MOTHER
14. Maiden name: Susan B. Norris
15. Birthplace: Wash. Co., Md.

16. Informant: Mrs. Albert Charlton
Address: 1922 Va. Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1945 (month) (day) (year)
Cemetery or crematory: St. Paul's Cemetery
Location: Clearspring, Md. R D
18. Funeral director: Snyder-Rowland Funeral Home
Address: Clear Spping, Md.

19. Dec. 13 1945 (Date rec'd by registrar) Elliott Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11, 1945 3:40 A. at M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/1 - 1945, to 12/11 1945
and that I last saw her alive on 12/10 1945

	DURATION
Immediate cause of death: Chronic - Endocarditis	?
" arteriosclerosis	?
Due to: Cerebral Hemorrhage	7 days
Due to: V	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Victor D Miller M. D. or other
DR. VICTOR D. MILLER
Address: 134 W. WASHINGTON ST. Date signed: 12/12/1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
DEC 15 1945

127

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

1281 362 Reg. Dist. No.

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
41 East Franklin St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wash.
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 41 E. Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war –

3.(a) FULL NAME Ira Wilmington Sprecher

3.(b) Social Security Number 214-09-9122

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Catherine Sprecher
6.(c) If alive, give age 38 years
7. Birth date of deceased (mo., day, yr.) March 8, 1890

8. AGE: Years	Months	Days	If less than one day
55	9	9	hrs. min.

9. Birthplace Tilghmanton, Wash., Md. (Town, county, and state)
10. Usual occupation Sheet Metal
11. Industry or business Aircraft

FATHER
12. Name Daniel Alex Sprecher
13. Birthplace Tilghmanton, Md.

MOTHER
14. Maiden name Annie Moats
15. Birthplace Tilghmanton, Md.

16. Informant Mrs. Catherine Sprecher
Address Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20 1945 (month) (day) (year)
Cemetery or crematory Manor Cemetery
Location Tilghmanton, Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown, Md.

19. DEC. 20 1945 (Date rec'd by Registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24 1945 to Dec. 17 1945 and that I last saw him alive on December 15 1945

Immediate cause of death	Coronary thrombosis	DURATION 3 weeks
Due to		
Due to		
Other conditions	None	

(Include pregnancy within 3 months of death)
Major findings of operations No operations Date of op.
Autopsy results No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. A. Bird M. D. or other
Address Hagerstown, Md. Date signed 12/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Washington County

City or town: Williamsport RFD #2 MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
68 yrs

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Williamsport RF. #2
(If outside city or town limits, write RURAL and give nearest town)
Pinesburg Md

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward Benjamin Staley

3.(b) Social Security Number: 220-29-9252

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna Banzhoff Staley

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Nov. 27 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	0	26		

9. Birthplace (Town, county, and state)

10. Usual occupation: Leather Finisher

11. Industry or business: Byrons Tannery

FATHER
12. Name: Joseph Staley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Ann Martin
15. Birthplace: Maryland

16. Informant: Edna B Staley
Address: Williamsport Md FRD #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26 1945 (month) (day) (year)

Cemetery or crematory: St. Pauls Cemetery

Location: Western Pike near ClearspringMd.

18. Funeral director: Edith V Leaf

Address: #7 Church St. Williamsport, Md.

19. December 26, 1945 (Date rec'd by registrar) Mrs Edna M. Elroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1945, at 6 o'clock M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943 19.., to Dec 23, 1945 and that I last saw him alive on Dec 22, 1945

Immediate cause of death	DURATION
Chronic Myocardial Sclerosis	2 yrs.
Due to: Died suddenly in his sleep.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David R. Brewer M.D.
M. D. or other

Address: Clear Spring Md Date signed: 12/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42a)

CERTIFICATE OF DEATH

★ 12813

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.: W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Margaret Tamson Stotler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles M. Stotler
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 6, 1862

8. AGE: Years	Months	Days	If less than one day
83	9	24	— hrs. — min.

9. Birthplace: Morgan Co., W. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Thomas Stotler
13. Birthplace: Morgan Co., W. Va.

MOTHER
14. Maiden name: Elizabeth Ann Bishop
15. Birthplace: Morgan Co., W. Va.

16. Informant: Edward A. Stotler
Address: Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 4, 1946 (month) (day) (year)
Cemetery ~~or crematory~~: Oakland Methodist Church
Location: Oakland, W. Va.

18. Funeral director: Charles R. Bast
Address: Hancock, Md

19. January 3 1946 (Date rec'd by registrar) J. P. Keller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-30 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-30 1945, to 12-30 1945 and that I last saw h. alive on 12-30-45 19—

Immediate cause of death	DURATION
Coronary Embolism	2 hours
Due to Metastatic Carcinoma	
Due to Carcinoma Cervix	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Herbert R. Zobias M.D.
M. D. or other
Address: Hancock Md. Date signed: 1-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

CERTIFICATE OF DEATH

12814

Reg. Dist. No. 7203

1. PLACE OF DEATH:
County Washington
City or town Rural - near Huyetts Crossroads
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
Huyetts Crossroads
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Rural - near Huyetts Crossroads
(If outside city or town limits, write RURAL and give nearest town)
Street No. near Huyetts Crossroads
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME: Mary Jane Carson Streightiff

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Daniel Streightiff
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) March 28, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	8	29	....hrs. ....min.

9. Birthplace Amaranth, Fulton Co., Penna.
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business —
FATHER 12. Name Robert Carson
13. Birthplace Ireland
MOTHER 14. Maiden name Sarah Hoopengardner
15. Birthplace Fulton Co., Penna.
16. Informant Mrs. Harry Streightiff
Address Huyetts Crossroads
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30, 1945 (month) (day) (year)
Cemetery or crematory Amaranth Brethren Church
Location Amaranth, Penna.
18. Funeral director Charles R. Bast
Address Hancock, Md.
19. Dec. 29 (Date rec'd by registrar) 1945 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1945 at 6 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Dec 27 1945
and that I last saw h~~im~~ alive on Dec. 26 1945

Immediate cause of death	DURATION
Arteriosclerosis, Pneumonia	27 days
Due to	
Due to None Known	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Williamsport Md. Date signed 12/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

#8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12815 Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington County

City or town: Williamsport, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 yrs

Hospital, Institution, or street address where death occurred: Williamsport, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Williamsport, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. Williamsport, Maryland (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Roman Franklin Taylor

3.(b) Social Security Number: 220-09-7707

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel Clark Taylor

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): April 10 1878

8. AGE: Years	Months	Days	If less than one day
67	8	20	hrs. min.

9. Birthplace: Franklin County (Town, county, and state)

10. Usual occupation: Mechanist

11. Industry or business: Bester & Long Co. Hagerstown

FATHER 12. Name: Joseph Taylor

FATHER 13. Birthplace: Franklin Co. Pa.

MOTHER 14. Maiden name: Sarah J Hose

MOTHER 15. Birthplace: Franklin Co. Pa.

16. Informant: Ethel Clark Taylor

Address: Williamsport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31 1945 (month) (day) (year)

Cemetery or crematory: Riverview Cemetery

Location: Williamsport, Md.

18. Funeral director: Edith V Leaf

Address: Williamsport, Md.

19. Dec. 31 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 1945 at 6 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to Dec. 29 1945 and that I last saw him alive on Dec. 28 1945

Immediate cause of death	DURATION
(a) Carcinoma of Larynx	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Williamsport Md Date signed 12/31/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

12816

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 62 North Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: R. Ellsworth Thornburg

3.(b) Social Security Number: 214-14-6495

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Catherine Thornburg

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 12, 1861

8. AGE: Years	Months	Days	If less than one day
84	10	15	..... hrs. ..... min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Clerk

11. Industry or business:

FATHER
12. Name: Robert C. Thronburg
13. Birthplace: Hagerstown, Maryland

MOTHER
14. Maiden name: Mary E. Carson
15. Birthplace: Hagerstown, Maryland

16. Informant: Robert C. Thronburg
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. DEC 29 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1945 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/21 1942 to Dec 27 1945 and that I last saw h... alive on Dec 27 1945

Immediate cause of death	DURATION
Fracture left hip	12/16/45
Carcinoma Prostate	4/21/42
Due to:	
Due to: Accidental fall. Slipped on floor, while walking.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of December 27th, 1945

Where did injury occur? Hagerstown, (City or town) Washington, (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Washington County Hospital

Means of injury: Accidental fall Injured at work?

23. SIGNATURE: H. L. Porterfield M.D.
M. D. or other

Address: 136 W Washington Date signed: 12/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

12817 16

★ Reg. Dist. No. 306

1. PLACE OF DEATH:
County: Wash
City or town: Near Leitersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yr
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wash.
City or town: Near Leitersburg rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. — — —
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Mary Cecelia Troupe

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Herbert Troupe
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 10-1900

8. AGE:

Years	Months	Days	If less than one day
45	8	24	hrs. — min.

9. Birthplace: Blue Rock Pa. (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business:

FATHER
12. Name: Charles W. Bowers
13. Birthplace: Blue Rock Pa

MOTHER
14. Maiden name: Mary Elizabeth Cole
15. Birthplace: Blue Rock Pa

16. Informant: Herbert Troupe
Address: Smithsburg R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-18-1945 (month) (day) (year)
Cemetery or crematory: Green Hill
Location: Waynesboro Pa

18. Funeral director: Geo. B. Hoover
Address: Smithsburg Md

19. Dec 16 1945 (Date rec'd by registrar) Geo. B. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1945 at 5-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July — 1942, to Dec 15 - 1945
and that I last saw it alive on Dec 8 - 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	Instant
Due to: Generalized arteriosclerosis and	
Due to: Chronic hypertension	10 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter H Wishard M. D. or other
Address: Waynesboro Pa Date signed: Dec. 16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63

CERTIFICATE OF DEATH

12818

133

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
785 Hamilton Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 785 Hamilton Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie K. Updegrove

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ellis L. Updegrove

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 17, 1871

8. AGE: Years	Months	Days	If less than one day
74	8	3	hrs. min.

9. Birthplace: Waynesboro- Franllin- Pa.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER
12. Name: David W. Miner
13. Birthplace: Franklin Co., Pa.

MOTHER
14. Maiden name: Sarah H. ------
15. Birthplace: Franklin Co., Pa.

16. Informant: E. Ramon Updegrove
Address: 785 Hamilton Blvd. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23, 1945 (month) (day) (year)

Cemetery or crematory: Green Hill Cemetery

Location: Waynesboro, Pa.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Dec 23 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20, 1945 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1929 to Dec. 20, 1945 and that I last saw h-- alive on Dec. 20, 1945

Immediate cause of death	DURATION
Pulmonary Embolism	12-10-45
Cardiac Failure	12-12-45
Due to Thrombosis	1938
Chronic Myocarditis	1938
Due to Chronic Art. Nephritis	1940
Chronic gen. Arterio.	1929
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Harold Updegrove M. D. or other

Address: Hagerstown, Md. Date signed: Dec. 22, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

CERTIFICATE OF DEATH

1281 302 Reg. Dist. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution or street address where death occurred: 708 W. Washington St;
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Funkstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Clara M. Whorton

3.(b) Social Security Number: -- --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Emory Whorton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 13, 1872

8. AGE: Years	Months	Days	If less than one day
73	0	3	..... hrs. ..... min.

9. Birthplace: Mt. Lena Wash. Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own Home

FATHER
12. Name: George Harmon
13. Birthplace: Frederick County Md.

MOTHER
14. Maiden name: Martha Lumm
15. Birthplace: Mt. Lena Md.

16. Informant: Mr. Leroy Whorton
Address: 708 W. Washington Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 19, 1945 (month) (day) (year)
Cemetery or crematory: Funkstown
Location: Funkstown Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown Md.

19. Dec 19 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1945 at 11:50p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16, 1945 to Dec. 16, 1945 and that I last saw her alive on December 16, 1945

Immediate cause of death	DURATION
Status Epilepticus	24 hours
Due to	
Due to	
Other conditions: Epilepsy	Since childhood

(Include pregnancy within 3 months of death)

Major findings of operations: No operations Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: La Bree M. D. or other
Address: Hagerstown, Md. Date signed 12/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Diat. No. 128211 302

1. PLACE OF DEATH:
County Washington
City or town Funkstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75-8-8
Hospital, Institution, or street address where death occurred: Funkstown
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Funkstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Emory Whorton

3.(b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara M. Whorton
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): April 3, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	8	....hrs. ....min.

9. Birthplace: Near Funkstown Wash. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: John Whorton
13. Birthplace: Unknown

MOTHER
14. Maiden name: Nancey Nally
15. Birthplace: Tilgmanton Md.

16. Informant: Leroy Whorton
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 13, 1945 (month) (day) (year)
Cemetery or crematory: Funkstown
Location: Funkstown Md.
18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown Md.

19. Dec. 13 1945 (Date rec'd by registrar) Chas H Boarer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11 1945, at 7:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1945, to Dec. 11, 1945 and that I last saw h... alive on December 10, 1945

Immediate cause of death	DURATION
Bronchopneumonia	4 days
Due to	
Due to	
Other conditions Chronic cardiovascular disease	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations ....Date of op.
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: LaBeau M. D. or other
Address: Hagerstown, Md Date signed 12/12/1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING